EXHIBIT

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UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF OHIO

EASTERN DIVISION

IN RE: NATIONAL PRESCRIPTION OPIATE LITIGATION	)	MDL No. 2804
	)	Case No. 17-md-2804
	)	Judge Dan Aaron Polster

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ORAL AND VIDEOTAPED DEPOSITION OF

VEERINDER TANEJA, MBBS, MPH

August 30, 2023

Volume 1

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ORAL AND VIDEOTAPED DEPOSITION OF VEERINDER TANEJA, MBBS, MPH, produced as a witness at the instance of the Defendant, and duly sworn, was taken in the above-styled and numbered cause on the 30th day of August, 2023, from 10:06 a.m. to 3:55 p.m., via videoconference, before Abigail Guerra, CSR, in and for the State of Texas, reported by machine shorthand, where all attendees appeared via Zoom in their respective locations, pursuant to the Federal Rules of Civil Procedure and the provisions stated on the record or attached hereto.

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(Appearing Remotely)

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(Appearing Remotely)

ALSO PRESENT:
Mr. Gregg Holderman
Ms. Megan King, Videographer
Ms. Sadie Turner

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THE VIDEOGRAPHER: We're on the record at 10:04 a.m. on August 30th, 2023. This is the deposition of Veerinder Taneja in the matter of In Re: National Prescription Opiate Litigation, filed in the Northern District of Ohio, Eastern Division, case No. 17-MD-2804. This deposition is being conducted remotely.

At this time counsel, please, state your appearances for the record.

MS. AYACHI: Leila Ayachi -- I'm sorry. Go ahead.

MR. CARDI: I'm sorry, Leila. Go ahead.

MS. AYACHI: Sorry.

Leila Ayachi, Lanier Law Firm, for client Tarrant County, and Sadie Turner is also from Lanier Law Firm.

MR. CARDI: Michael Cardi, Bowles Rice; counsel for the Kroger entities.

MR. FOX: And, also, Chris Fox with Bowles Rice for Kroger.

MR. PRICE: Craig Price for Tarrant County.

VEERINDER TANEJA, MBBS, MPH, having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. CARDI:

Q. Good -- it is morning. Good morning,

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Dr. Taneja. Michael Cardi, Bowles Rice, as stated just a moment prior, counsel for the Kroger entities in this matter.

Your voice is a little bit distant sounding to me. So if I ask you to repeat yourself, maybe that's why, or maybe, yeah. Any ways want to let you know.

Will you, please, state your name, sir?

A. Yes.

It's Veerinder Taneja.

Q. Dr. Taneja, where do you presently reside?

A. In Tarrant County in Southlake, Texas.

Q. Southlake, Texas?

A. Yes, sir.

Q. Okay.

How long have you resided in Tarrant County?

A. Coming up to almost nine years.

Q. Is that about the time that you began your work at the Public Health Department of Tarrant County?

A. That is correct, yes.

Q. Okay.

Sir, have you been deposed before?

A. No.

Q. Okay.

Is there any reason health related or

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for due to the use of any prescription drugs or other drugs, you cannot testify accurately and truthfully today?

A. No.

Q. Thank you, sir.

It's important throughout the day that we try to let each other finish our questions and answers before we begin. It's likely that I will break that rule at some point accidentally, but it's important that we try to do our best there.

It's also important that responses to questions are verbal in nature, not shakes of the head. That can certainly accompany your answers, but it's important to be verbal as well.

A. Understood.

Q. Thank you, sir.

If you don't understand any of my questions, let me know. If you don't hear me, ask me to repeat myself. Otherwise, I'm going to assume that you've understood what I have asked, okay?

A. Okay. Will do.

Q. Going to try to take regular breaks about every hour. If I forget, I'm sure someone will let me know. Please feel free to let me know yourself.

Also, if you need to take a break for any

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reason, just let me know. Well, hopefully, be able to finish the question presented, and then I'm happy to take a quick break, okay?

A. Okay.

Q. Where are you testifying from today, sir?

A. Fort Worth, Texas.

Q. What offices?

A. It's Public Health location at Mercantile Drive in Fort Worth.

Q. Okay.

Are you in your office?

A. Yes, that is correct.

Q. Okay.

Is there anyone else in the room with you?

A. Yes.

Our DA, Craig Price. You can see on him the screen, but he's in my office.

Q. Yes, okay.

Counsel for Public Health Department?

A. Yes.

Q. Is that accurate?

A. Yes.

Q. Okay.

A. Yes, that is correct. He's our county civil division chief.

Q. You have a couple of binders in close proximity that have been delivered to you?
A. I have one binder.
Q. Okay.
Other than that binder, do you have any other documents within viewing distance?
A. Yeah.
But it's my office-related, like, notepads and things. Nothing related to this matter.
Q. Okay.
Nothing that you've specifically brought with you or put nearby for purposes of the deposition today?
A. No, sir.
Q. Okay.
Do you have any email or -- or phone up to receive messages during this deposition?
A. Yeah, emails up. But if you need me to shut it down, I can.
Q. Well, do you need to have email open for purposes of your -- of your work with --
A. Yeah.
Q. -- the department?
A. Yeah.
Q. Okay.

A. Like I received a phone call just now and emails flying related to that. That's why I have it up.
Q. Okay.
Well, if anything arises in that nature, just let me know. I gather and assume that you will not be communicating with anyone about this deposition or about my questioning throughout today.
A. Yes, sir.
Q. All right.
What did you do to prepare for the deposition today?
A. I'm sorry. You cut out. Can you repeat your question? Because I don't know what's happening with the audio.
Q. Yes, sir.
What did you do to prepare for your deposition today?
A. Nothing specific other than a couple of meetings with our attorneys just to make sure we know what depositions are like.
Q. Sure.
And what attorneys did you meet with?
A. So a couple of the folks from Lanier Law Firm, Leila Ayachi and Sadie Turner. And on one of the calls, Mr. Price was present as well.

Q. Was there anyone else present at those meetings other than the counsel you just mentioned?
A. Not that I'm aware of. I don't believe so.
Q. Were there two meetings in preparation?
A. Two meetings, yes, sir.
Q. Roughly, how long was the first meeting?
A. Half hour. Maybe 35 minutes.
Q. How about the second meeting?
A. Maybe about an hour.
Q. All right.
Did you review any documents in anticipation for --
A. No, sir.
Q. -- of your deposition?
A. (Moving head side to side.)
Q. Have you reviewed any deposition transcripts of depositions taken in this litigation?
A. No, I have not.
Q. At any point. I wasn't referring to just in preparation. Just to be clear.
A. No.
I mean, this is my first deposition, so I have not ever.
Q. Okay.
A. Yeah.

Q. Have you at any point reviewed the complaint filed in this litigation against the Kroger entities?
A. No, I have not.
Q. All right.
Is there anyone else that you spoke with other than counsel in preparation for your deposition today?
A. Not in preparation, but just to inform a couple of people in my chain of command. So the county administrator.
And it just so happened, I was being asked to come see the county judge like right now. So I told her office that I was doing a deposition, and I can't come right now. So those are the two parties that are aware. And then my assistant that helped coordinate the times and all that.
Q. In any of those discussions, did you address anything of substance in relation to the deposition today?
A. No.
Other than that I'm being, you know, invited to be deposed. They didn't ask, and I didn't answer. I mean, you know, there was no other -- there was no other discussion. I guess they're aware that there's depositions going on.

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Q. Did you personally prepare any notes, summaries, outlines in preparation for this deposition?
A. No.
Q. Okay.
From time to time during the deposition, I may use acronyms, shorthand names for things. If you don't understand what I'm referring to at any point, please let me know.
Is there an acronym for the Public Health Department that is commonly used by you and your department?
A. "TCPH." It's the acronym for Tarrant County Public Health.
Q. So if I use the acronym TCPH, you will understand that I'm referring to the Tarrant County Health Department, fair?
A. That is correct, yes.
Q. Okay.
If I say "this case" or "this litigation," you understand that I am referring to the lawsuit that Tarrant County has brought against Kroger and others related to prescription opioids?
A. Yes, that is correct.
Q. That's fair? Okay.
If I use the term "prescription opioids"

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today, what is your understanding of my use of that term?
A. So, you know, opioids is a class of drugs that is used for pain management usually morphine; and codeine; and hydrocodone; and a few others like Vicodin; and all that. So that's kind of first thing that comes to mind when you talk prescription opioids.
Q. Is it fair to say that prescription opioids are pharmaceuticals that can be legally prescribed for a legitimate medical use?
A. Yes.
Q. Okay.
A. That's the original intent.
Q. Sure.
What about the word or the term "illicit opioids"? What's your understanding of that term?
A. Right.
So illegal drugs, or street drugs. You know, a lot of people have -- use heroin, and, now, there's the new synthetic opioid, fentanyl. So those are a couple of names that come to mind that are illicit, or illegal opioids, that are in use.
Q. I believe you have spoken of a couple differences between prescription opioids and illicit opioids.

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Is there anything else that comes to mind to differentiate the two?
A. Not that I can think of, no.
Q. Okay.
What degrees do you hold?
A. Yes.
So I have a medical degree from India. It's called MBBS, bachelor's in medicine and bachelor's in surgery. They follow the old British system, but it's equivalent to an M.D. here.
And then, you know, to practice in the U.S., you got to go through the licensing here, which I did not. And then from the U.S., I hold a master's in public health. MPH degree.
Q. Where did you get your MBBS?
A. Yes.
It's at Kasturba Medical College in India, and the university or the conferring -- -- degree conferring authority is Manipal Academy of Higher Education.
Q. And what year did you obtain that degree?
A. In 2001.
And the process is a little different. So it's a four-and-a-half year of medical school and one year of internship. So you get licensed as part of that

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degree package, and so everything gets confirmed at the end of the licensing period after the internship. So 2001 was when I got my degree.
Q. And when did you get your master's in public health degree?
A. It was in 2003.
So I came to the U.S. in the fall of 2001 to get my MPH, and it was a two-year degree program. So I graduated in 2003.
Q. And what institution did you obtain the degree?
A. Eastern Kentucky University in Richmond, Kentucky.
Q. Have you lived in the United States since 2001?
A. Correct.
Q. You mentioned that you did not go through whatever certification or licensing was required to transfer your medical degree to the United States.
Am I saying that correctly?
A. Yes.
That is called the United States Medical Licensing Exam, and I stuck in public health and didn't ever go back to do a residency here, or anything like that. So I did not.
Q. Okay.
So you are not presently licensed to

practice medicine in the United States?
A. Correct.
Q. Correct?
A. Yeah, I'm not a practicing physician in the United States.
Q. Have you ever practiced medicine?
A. Other than my internship, that was it. None other than that. Because I came straight after that to the U.S. for a master's in public health.
Q. Since your master's in public health degree was conferred in 2003, you worked in the field of public health?
A. Yes.
All throughout my career. In fact, I started my first job in November of 2002 at a local health department as an epidemiologist.
So I've been working in public health, even before I graduated because I had a medical background. So I was qualified to start the job. And so I've been working since 2002 pretty much nonstop.
Q. In 2002, you worked at regional -- as a regional epidemiologist, Madison County Health Department; is that accurate?
A. Yes.
That was the health department in Richmond,

Kentucky where my school was. Yes, that was my first job in public health.
Q. Okay.
And I'm looking at what, I believe, is your LinkedIn profile. Want to sort of talk through it.
How long did you work for the Madison County Health Department?
A. About a year, I believe, or maybe a little bit less than a year.
Q. What were your responsibilities in that role?
A. So I was a regional epidemiologist serving 11 counties, and Madison County was the fiscal agent where they received grant funds to hire staff. The idea was, like, after 9/11 that they wanted to expand local health department capacity to have more epidemiologists. Anthrax letters and things were going around at that time, and they wanted assets in place to investigate those situations. Make sure if anything -- if an outbreak to occur that they had local people ready to respond.
So that was kind of the job to make sure we look at all the disease outbreaks because most health departments did not have epidemiologists at the time. They were only usually at state health departments.
And the grant was sent out to make sure

they build local capacity. And the first setup was to hire people regionally, and those regionals epis would be housed in a health department, but they would serve multiple neighboring counties around them.
Q. What is the unique role of an epidemiologist within a Public Health Department as opposed to what other employees present?
A. Yeah, the simplest way to explain is epidemiologists are disease outbreak investigators. We chase after outbreaks.
Q. Outbreaks of any nature?
A. Of any nature.
Generally, they end up being disease outbreaks that are the most frequently occurring. You know, flu outbreak. COVID was a good example recently.
A lot of times, there's food-born related outbreaks. Somebody goes to a restaurant. A group of people, five, six people, a party, and they end up all being sick. Those are common examples.
But then there are other things, you know, environmental related. You know, what we are talking about today, drug related. Anything that goes out of the ordinary in your community, and it's affecting a lot of people and their health, a lot of those are outbreaks that epidemiologists end up investigating.

Not all outbreaks are investigated by a local epidemiologists. Some are investigated at a higher level like at the CDC or the state, along with the local. But, generally, the most common day-to-day things -- foodborne outbreaks and illnesses outbreaks -- are investigated by local epidemiologists.
Q. Is it fair to say that local epidemiologists, at least within public health departments, are only addressing, investigating diseases and illnesses affecting human beings as opposed to animals, or...
A. That is generally true.
What is -- again, it's a very large country with a large local flavor. I am aware of epidemiologists that, you know, sometimes are housed within a health department, but they work with, like, university extensions; and they are more focused on plant or animal outbreaks.
Even local health departments a lot of times have veterinarian doctors as their epidemiologists because a lot of animal outbreaks can spill over into humans. So there is some variation there.
But, generally, you're right. Mostly, we deal with human outbreaks only because Public Health Departments mostly deal with prevention of health issues in humans.

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Q. According to your LinkedIn profile, you transition to the state of South Carolina in September of 2003 as a regional epidemiologist; is that accurate?
A. Yes.
So it was pretty much similar role under Public Health Preparedness. Same concept, regional epi. The only difference was South Carolina is a state-centralized public health system where all the health departments are under the state umbrella. They are state entities.
So the hiring entity was the state of South Carolina, but I was placed in a local health department serving about ten counties; and they had formulated under two districts at the time. So four counties in one district and six in the other, but I was a regional epi. Same concept like in Kentucky.
Q. Okay.
And then Brown County in 2004; is that accurate?
A. That is correct.
Brown County. That's Green Bay, Wisconsin, yes. And I was there. There were 12 health departments in consortium, sort of the group that I served.
Q. Otherwise, did your responsibilities change

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much in Brown --
A. No.
Q. -- County?
A. No. I mean, just with the sign of times going from paper-based outbreak surveillance and other, you know, investigations do more like electronic surveillance because electronic systems were rolling out. So part of the responsibilities were added to train local health department staff and nurses on how to use electronic surveillance systems because it was new for everybody.
And epidemiologists, because our job is so involved with databases and investigations, we're sort of the natural choice. Like, y'all, teach everybody to learn all of these new things, but that's it.
Otherwise, the core of the job was the same. Disease-outbreak investigations and public health preparedness because that was a grant that was funding all these roles that I had in the beginning. So it was a lot of, you know, involvement in the planning, training, and exercising related to any either national disasters or man-made outbreaks that may lead into, you know, a public health emergency of sorts.
Q. During your time in Brown County, do you recall addressing opioid use in your position as an

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epidemiologist in the Public Health Department?
MS. AYACHI: Objection to form. Sorry. Objection to form.
A. I don't recall. It's been a long time.
THE CERTIFIED STENOGRAPHER: This is the court reporter. Was there an objection placed?
MS. AYACHI: There was. Can you not hear me?
THE CERTIFIED STENOGRAPHER: It was just cross-talk.
MS. AYACHI: I'm sorry. I apologize.
MR. WAHBY: Let me also say, this is Peter Wahby of Greenberg Taurig, appearing for the Albertsons defendants. I was a few minutes late because the link didn't seem to work, but I see Mr. Cardi went ahead and started. I just want to make sure my appearance is noted for the record.
MR. CARDI: Peter, I apologize. We didn't -- we didn't wait for you there.
Q. (BY MR. CARDI) During your time in Kentucky as a regional epidemiologist, do you recall addressing opioid use through your work at the Public Health Department?
A. No, I don't recall. It's been 20 years or so. Long time.

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Q. Accurate that you transitioned to Tennessee in 2010?
A. That is correct.
Q. And I have on the LinkedIn profile that you were a PHIN coordinator; is that accurate?
A. Yes.
So the technical term is public health information network, and the software system was National Electronic Disease Surveillance System.
So what I mentioned when I was in Brown County, a lot of electronic systems came into play for disease surveillance and investigations and so forth. And because I was good at explaining to people how these things work, I got selected to be the PHIN coordinator or the NEDSS coordinator for the state of Tennessee.
Stayed there only about six months. I had applied for multiple jobs like lot of people do when they're looking for opportunities and got an opportunity in Wisconsin in Milwaukee. So I ended up moving back to Wisconsin. Because I had lived in Green Bay for a long time, so kind of felt like home for a while.
Q. Sure.
These electronic systems that you're referring to, is this the CDC's electronic disease surveillance system?

A. That is correct.
Q. Can you explain that to me?
A. Yes.
It's called the National Electronic Disease Surveillance System, and the idea is that local health departments used to investigate all these things on paper, which took a while, and then the reports were sent to the state, and people would transcribe that, and report that to the CDC. So by the time all of that data was collected, and national patterns or state patterns were detected, hey, there's an outbreak in Fort Worth and the same outbreak happening in Dallas and the same outbreak happening in Austin, it was too late to make that connection. So the idea came that let's do this electronically so close to realtime monitoring of these situations needs to happen.
So NEDSS was created. But as with anything federal, they usually do not mandate that all must use this. So they created a national framework.
Some states chose to use the NEDSS system. Tennessee was one of them. Texas was also one of them. But then some states like Wisconsin went with third-party solutions that were NEDSS compliant. So they were able to report data into NEDSS per NEDSS requirement, but the user interface looked a little

different because they were third-party solutions by private vendors.
Q. Is NEDSS a platform to input and share data solely, or does it also offer tools to actually collect the data on a local level?
A. It offers tools to collect the data at a local level where you don't have to do the investigation on paper. You can actually put the data right into the system while you're doing the investigation.
And also laboratory reports are connected on the back end. So somebody goes to a doctor, and they have a disease. Let's say TB, just an example.
A lab report will come into the health department. Hey, Vinny, this person has TB. So we can start our investigation right there from calling the doctor's office, looking at the lab report, connecting all the dots, interviewing the person, getting all the information around that situation, and get all that case documentation worked into the system right away.
Q. The means to collect data changed over time since your early days of your career in early 2000s to present?
A. Yes.
Lot more focus on electronic data collection and lot less on paper. Although, paper is

still present. To me, like in most operations, paper is hard to get rid of.
Q. At present, the Tarrant County Public Health Department, where does data come from that is collected, reviewed by the Public Health Department?
A. Multiple places.
But a lot of physician offices and laboratories still fax us stuff, and we've pushed very hard to get them all electronic during COVID because fax was just overwhelming.
So a lot has shifted to electronic means of reporting, and it comes in many different ways. So there's laboratory data that comes in something called electronic lab reports, and we have a NEDSS-compliant system called EpiTrack. So a lot of that data goes into that system.
We also have other surveillance systems set up. Something called the Syndromic Surveillance System {sic}, NSSP. It's another CDC platform. It looks at ER visits and reports related to various situations that people present with. So that's another early-warning data source, if you will.
And those are a couple of things. So laboratory reporting, physicians reporting through us through faxes. And then, of course, you know, NSSP

data. Those are three main ways that I can think of. I'm sure there's phone calls and other things that happen, but, you know, those are generally how we worked.
Q. You say SS data?
A. Yes. Syndromic Surveillance data.
Q. Okay.
A. It's NSSP. Syndromic System platform.
Q. Okay.
These are the three manners of collecting data primarily, I believe, you said presently --
A. Correct.
Q. -- as of 2023?
A. Yes.
Q. Have all of these systems for collecting data been in use since you began at Tarrant County Public Health?
A. Yes, in various stages of development sometimes. Because as time progresses, things become more refined.
And the other thing that we should mention probably is there's something called QuickBase. It's -- really, it's a low-code database that you can configure to do whatever you want to do. It's a database tool.
And during COVID, a lot of our systems were

not ready to deal with the volume that was going to be coming in. So we -- for COVID specific, we did a lot of stuff in QuickBase, and, now, we're sort of phasing everything back into our, you know, TriSano, the NEDSS-compliant system.

But COVID, monkeypox, a couple of those examples were handled in QuickBase because how quickly we could turn things around versus other systems need more like IT help and vendor help to configure them. QuickBase was, like, epidemiologists can go in and create a form, and you can do whatever you need to do.

Q. As the collection of data through physician office faxes, as we've discussed, has it altered or changed over the past ten years?

A. Yes.

So it was primarily faxes. To now, there's some -- a lot of the larger hospital systems are slowly switching to something called e-case reporting. Not all of them are on board with that. But I know a couple of large system hospital systems in Tarrant County are doing electronic case reporting, or e-case reporting.

Where out of their electronic medical record, we get a report saying, okay, Vinny is in our hospital or under physician care. Here's what we think is his diagnosis. And then a lot of times, laboratory

tests are sent in, and the lab reports come in. Yep, Vinny tested positive for such-and-such disease. And those two are connected, and then we, kind of, start working from there.

But there's still physician offices, private practices faxing in things that they're required to fax in or send us to -- there's about 80 conditions in Texas that are reportable. A lot of states have their own list, but generally there are 70, 80 physicians that are part of the national surveillance program, if -- disease surveillance program. And most states adopt those and report those to local health departments and state health departments and then to CDC.

Q. Are any of the 70 to 80 conditions collected through the surveillance program related to opioid use or abuse?

A. So not directly named like that, but there is a sort of a generic term in there that anything that may create an outbreak in your community -- and I'm kind of paraphrasing so we can understand what that means -- that must be reported to your health department, whether it's a state or a local.

So opioids would fit under that if they create an outbreak. So, usually, outbreak is in

simplest terms, something out of the ordinary in your community. Usually, like, if something doesn't occur in your community and one or two people have it, that's an outbreak. I mean, that's the simplest way to explain it.

And so anything that occurs out of the norm that creates a health impact in the community, that is an outbreak, and it must be reported to a public health department, either state or local. So they can investigate and see what is happening in terms of health impact.

And that's where these opioids and many other out of the ordinary things that are not named items on that list fall under.

Q. Do you recall a reporting through the NSSP surveillance system of outbreak-related opioid use?

A. So not that I can recall, but we are observing trends with, like, ER visits and such related to drug overdoses going up over the last few years.

Q. Who would actually report an outbreak as we've discussed through the surveillance system? Is it physicians?

A. I'm sorry. Could you repeat your question? Because my audio cuts out for some reason for a second there.

Q. Absolutely.

Who would report an outbreak, as we've discussed it, through a surveillance system? Is it just physicians, or is it also public health officials?

A. Yeah.

So under state law, anybody who is aware of an outbreak is supposed to report. And generally, like, you know how state laws are. They'll give you an example, but not limited to, right? And so they name people like, you know, school superintendents and physicians, laboratories, infectious control practitioners and so forth; but then it's generic enough that anybody who's aware of an outbreak should report.

Do people actually understand and follow that? That's not always the case. With many state laws, that's how it happens. But, generally, the reports come through physicians' offices and also through laboratories.

And the lab may not necessarily say, here's an outbreak, but they will send us multiple reports of different diseases; and then we end up connecting the dots. Hey, this is out of the ordinary. This is an outbreak.

And a lot of times, physicians' offices may notice something. Hey, we think there's an outbreak

going on. I don't ever see that many kids that are coughing, and, now, I have 20 kids in my office over the last three days that were coughing. Three of them tested positive for pertussis. Should I test all of them for pertussis? Usually, those conversations, they pick up the phone and call and ask our advice and so forth.

Q. Would physician offices report opioid addiction through this system?

A. Generally, they don't.

And, again, it's because of a lack of understanding on how the law applies to that.

Q. What about overdoses?

A. So different setups. A lot of the overdose reporting is happening, I think, to, like, either poison control centers or just, like, through the ambulance systems. It is not necessarily at least happening in Tarrant County to Tarrant County Public Health.

So that's why we have these other systems in place just looking at ER data. So at least we're aware. Hey, there's a rising trend in our community, and that indicates a problem.

There are other entities in Tarrant County that are more hands-on. One example would be MHMR of Tarrant County. And then others would be like Medstar

ambulance company. They get a lot of calls per se. Hey, we have a drug overdose; you need to come. That kind of stuff.

Q. You mentioned other systems that would result in the reporting of overdoses to public health.

What are those systems?

A. So the NSSP Syndromic Surveillance platform. So we can look at ER data and put in some search terms to look at various trends, and it observes patterns and ER visits in the companies that are coming in to determine, hey, that's a valid concern.

The original intent was looking at various syndromes, right? It all started after 9/11. You know, white powder was going out. Is it going to create an anthrax that's inhalational? Or is it going to create an anthrax that's affecting the skin?

So that's kind of the basis of all that. So you could look at, like, rash-causing syndromes, respiratory syndromes. And over the course of the years, systems have been refined to look at various other things -- heat-related injuries, you know, showing up in the ER; opioid related stuff; COVID related stuff; flu surveillance. A variety of uses.

Q. If there's an overdose that occurs or an individual that has suffered an overdose who enters a

position office in Tarrant County, is it always reported into the surveillance system?

A. No.

Q. Is it usually reported into the surveillance system?

A. No, it's not.

And, again, when I say the "surveillance system," I'm talking about our NEDSS surveillance system. And like I said, it's not a named condition on the list; and, thus, a lot of physician offices don't always connect the dots that, hey, if they're seeing something that they feel is an outbreak that they need to report to Public Health. And it's not unusual for them to think of Public Health as a partner to report such things.

So we don't -- we don't receive those reports directly. But we do have partner entities like Medstar or MHMR where we talk to them, and they say, yeah, this is a growing trend in our community. And we're observing these calls or getting a lot of calls on going to respond to drug-overdose situations.

Q. Okay. I apologize. I'm just trying to understand.

I thought you said you are able to get onto the surveillance system -- maybe you didn't say that --

but to observe data and trends?

A. Yeah, I did.

So that is NSSP Syndromic Surveillance platform, and it looks at ER visits trend. So that's not a -- you know, it's an early-warning system. Hey, a lot of people showing up with these issues. And as we've noticed over the years, more and more ER visits happen related to drug overdoses in Tarrant County.

And then there's other things like medical examiner conversations. I was driving by yesterday, and there was a billboard on the highway that drug overdoses deaths are on the rise in Tarrant County. So it's a lot of -- community conversations also feed into that.

Q. But not every overdose in an ER would be in that system for you all to review and analyze, correct?

A. You know, probably.

It should be because it's an ER visit, but I can't say for sure that every one of them gets reported the way it's supposed to. But if it's an ER visit, we have an ability to look at that data, and -- it's not a -- what I would call, like, a definitive answer this is what caused it, but it's syndromic pattern, right? So people showing up with overdoses are on the rise. That's kind of the simplest way to explain it, and there's other ways to fine tune the data and

look at some, you know, what may be causing that. But it's an early-warning system, not a final-answer system.

Q. Would the data within the surveillance system differentiate between prescription and illicit opioids?

A. I'd have to go ask.

I believe so, yes. Because if the physician has made a determination that this was heroin versus this was hydrocodone, I believe we have the ability to parse that. But I have people who are experts on syndromic surveillance who are probably better suited to answer that.

Q. Absent a patient being admitted with heroin or prescription opioids on their person, is it typical that physicians in an ER would be able to and would report the form of opioid that is in the system and causing the overdose?

MS. AYACHI: Objection, form.

A. I -- yeah, I don't know. That's an ER physician question.

Q. (BY MR. CARDI) Okay. All right.

Other than the surveillance system, I believe, you mentioned Medstar and MSMR {sic} as sources you all would look to for trends in overdoses; is that accurate?

A. It's MHMR, My Health My Resource. They're the

mental health and substance abuse provider entity.

In simplest terms, Texas is kind of unique where physical health is dealt by with health department. Mental health is under another quasi-governmental entity. They're kind of like a health department, but they primarily deal with mental health and substance abuse issues.

And so MHMR is the entity in Tarrant County and in many other counties in -- in Texas, and they are the lead on mental health and substance abuse issues.

Q. And they collect data on opioid abuse?

A. I don't know the details, but I believe they do.

Q. And do they collect data on opioid overdoses?

A. I don't know. That's an MHMR question.

Q. What about Medstar? What is --

A. Medstar, I know that they collect data on drug overdose cause and any other details that they find.

Because I know there's been conversations about receiving that data. I can't recall if we're actively receiving it or not, but we did have this with them back in 2018, '19 to set up a way to receive their data so we can start looking at some of the details.

Q. Any other sources, to your knowledge, of data related to opioid use or abuse that the Public Health

Department has access to?

A. Yes.

So medical examiner data. We -- we have conversations with the medical examiner in Tarrant County, and then we have access to reporting systems. So it's not like primary data like raw information coming in.

But CDC Wonder is a CDC tool public facing. Our health department staff use that all the time because it gives you state-level and local-level breakdowns on various data sources that CDC collects from. A lot of that is from hospital systems and surveys and other things that they've done.

And, also, DHS, the Texas Department of Health Services has a website similar to that where you can go look at your county and see what's happening on various health issues including opioids. So they collect some of that data as well through various surveys.

And then -- and, again, talking about surveys, we do have a survey we do every three to five years. It's called Youth Risk Behavior Survey. And I don't know for sure if there's a question about opioids, but there's question about substance use, alcohol, tobacco, illicit drugs. I'm sure they ask some

details, but I don't know for sure if it goes into, like, defining opioids. It might just name, hey, do you use heroin or other illicit drugs or anything like that? So it does look at youth risk behavior.

So those are some of the data sources that the Health Department typically uses.

Q. On the youth risk behavior survey, does the Health Department conduct any other surveys with any regularity?

A. So the Health Department contracts out for the youth risk behavior survey and so does the state of Texas. So we collate from both.

And then we also do a community-health needs assessment, again, about every five years or so. And a lot of that is looking at a variety of data sources like the ones that I mentioned. So collecting sort of data from those, and then add in the community stakeholder meetings and conversations.

You know, not everything comes to the Health Department. So we talk to a lot of partners to figure out what is happening in the community that we may not have firsthand information on.

And it's a pretty standardized process. A lot of Health Departments do this across the country. You know, the hospital systems do this. They're

required by their accrediting bodies. And that's how we keep a pulse on what is happening in our communities in terms of what's impacting health.

Q. Do you know if the medical examiner data breaks down opioids into prescription versus illicit opioids?

A. I don't have firsthand knowledge because I don't deal with that every day.

Generally, I would think yes. Because their job is to determine what caused the death, but that's a medical examiner question. So I would defer you to them.

Q. What about CDC Wonder? Does the data as presented in that system differentiate between prescription and illicit?

A. I'll be honest, I haven't looked at that data set in quite a while.

So when I was an epidemiologist, I used to access that pretty frequently. Last ten years, I've been in administration. So I know that staff use it, but I don't necessarily pull that data up on my own.

So they -- they generate the reports and usually I'm good with that. So I haven't accessed it recently to, kind of, give you firsthand knowledge of what they've added or deleted from their data sets.

Q. What positions within the Tarrant County Health

Department would access that data and be more familiar with that data?

A. Absolutely.

So our biostatistician. Her name's Micky Moerbe. She accesses that on a pretty, regular basis because a lot of our reports cite CDC Wonder as our source, and she is usually the author of those.

There's other staff across the department. A lot of them are epidemiologists, or in our infomatics division that may access it. But the one person that does it on a regular basis would be our biostatistician Micky Moerbe.

Q. Okay.

Can you think of anyone else that comes to mind that would frequently deal with this data?

A. Epidemiologists mostly.

And it depends on what they're working on. Because if they're working just a disease outbreak, they're probably not going to look at that. But if their jobs entails other things -- because I have epidemiologists here that are focused on other things other than common disease outbreaks. So they may have injury prevention roles, and this is where some of that will fall under. They might be looking at like, you know, traffic accidents and helmet-related injuries, but

also drug abuse-related injuries or heat-related injuries, and that's where they'll be accessing some of that. Some of those databases that deal with those things like CDC Wonder.

Q. During your time as an epidemiologist in Brown County, do you recall addressing any issues related to opioid use or abuse?

A. Not that I recall.

I know the topic's been circulating for quite a while. So was I ever in any conversations with any Health Departments about this? Probably. But not that I can recall. It's been a long time.

Q. Okay.

You moved to the city of Milwaukee in 2010; is that accurate?

A. That is correct.

Q. You served as an epidemiologist to the city of Milwaukee?

A. That is correct.

I was one of two or three, I believe. Large city. So they had more resources.

Q. Did your responsibilities change between city of Milwaukee and Brown County?

A. A little bit. It was still an epidemiologist job, but the focus was very much on electronic disease

data warehousing. So sort of the back end.

A lot of health departments collected a lot of data, and the larger health departments collected a lot more data. And then they couldn't find the resources to get reports made out of that data, how to make sense out of all of that. So the job was to create a health data warehouse and create a lot of reports.

Q. Do you recall any initiatives related to opioid use or abuse during that time?

A. No, I don't recall at that time.

But, again, I was very focused on sort of the backend data and working with IT on how to build infrastructure to get reports out. I wasn't necessarily working on topics.

A couple of topics do come to mind. Like there was a clinic that deals with -- dealt with FTDs, and they had a heavy no-show rate. So I got asked to look at a quality-improvement project looking at the backend data, presenting to the team, hey, here's what your data is. And then they had to come up with methods to improve the show rates.

But not that I can recall anything related to any particular topics or related to opioids because it was very focused on building the infrastructure-technology aspect working with IT versus

the actual topical Public Health stuff.
Q. You transitioned to your role of deputy health officer in Wayne County, Michigan in 7/11; is that accurate?
A. That is correct.
Q. Did your responsibilities change in that role?
A. Yes.
So went into administration, and it was pretty much overseeing the entire Health Department's operations. It just so happened that the health director who recruited me ended up moving to Detroit.
So Wayne County is the county for Detroit, and Detroit had their health department and Wayne County had their health department. So we served everything in Wayne County except Detroit, and she got recruited into Detroit. So there was a vacancy.
So I was, kind of, the acting director. We were under a Health and Human Services. So the chief of operations sort of stepped in as the -- as the main guy, and I was, kind of, like the day-to-day guy.
You know, that's how it goes a lot times in government. They don't get to always get to show their positions fast. So we kind of split responsibilities, you know.
Q. Do you recall any specific initiatives or

concerns related to opioid use or abuse during your time as deputy health officer at Wayne County, Michigan?
A. Not specifically. But the topic was making circulation at the time.
Also -- but in the Wayne County, a lot of Middle Eastern communities settled in Dearborn, and so their main issues were related to hookah use, smoking. So a lot of smoking-related discussions I do remember, but not necessarily opioids. Other than just general awareness and public health that there is a rising trend across the country, things that could happen in your community also.
And by that time, it was starting to become, you know, more in the public health circle, hey, this is an upcoming issue that we need to be aware of.
Q. 2011 to 2014, what was becoming more aware in public health circles?
A. That opioids use was on the rise. And, also, that a lot of that was starting as prescription drug abuse, and, again, this was sort of anecdotal in public health circles. Listening to physicians, going to different meetings, and learning about -- again, the role of deputy director exposed me to a lot of higher-level discussions in public health and in government that allowed me to understand what are other

health issues coming.
As an epidemiologist, you're focused on your job, right? But as a deputy director and director, you're looking at the big picture of what else may be coming. So you try to have early understanding of what is happening in your community. So I did recall around that time that this was a topic that was sort of starting to come up on the radar in various public health circles.
Q. During this time frame, 2011 to 2014, what was the early understanding as to the cause of this rise in opioid use?
A. So one of the things that we understood at the time was that people were starting to abuse prescription opioids, and various examples could come to -- you know, in meetings they were being discussed that, you know, people would find leftover medications in a cabinet and then get hooked onto it after consuming those and things like that.
And so those conversations I do remember. Well, that's a -- that's a bad thing, right? I mean, you know -- so I remember those conversations had started around that time, but nothing specifically that I was involved in in Wayne County. Just general public health knowledge from attending national conferences and

national meetings and being exposed to topics other than what I was exposed in epidemiology, focused on disease outbreaks. This was more administration-level stuff that I was getting into.
Q. Other than the conversations that you had and can recall and anecdotal stories, do you recall any efforts to drill down and collect data as to the cause of this rise during that time period?
A. I do not.
But, again, with many places, we were a Public Health division of Wayne County Health and Human Services, and they had a mental health division that was a very large department, if you will. And, eventually, I think they spun off into Wayne County Mental Health Authority because they were so large. I believe that entity was, again, heavily involved in the substance abuse world.
And I also recall as the deputy health director, who is, kind of, the acting director there, being sent to some meetings. And I'm trying to remember the name of the organization, but the organization had a lot of SAMHSA funding related to substance use. Like I said, I recall from attending those meetings that people who dealt with it every day because that's what their entity was doing was -- they were starting to raise a

lot of noise about, hey, this is an upcoming trend. Health departments need to know. Mental Health Authority needs to know, and we all need to come together and start addressing this before this becomes a real problem in our community.

So it wasn't that, you know, -- because the Health Department is not the lead on this, that's why we're, kind of, on the tail end, but there were other entities that very entrenched because that's their, sort of, proper role. They deal with substance abuse.

Q. You mentioned theft as an early understanding of a cause in the form of theft from medicine cabinet and by family member.

Is that what you're referring to?

A. Yeah, that's one example.

I mean, that's kind of -- I mean, you know, my memory is not that super accurate --

Q. Sure.

A. -- from, like, ten years ago. But, generally, that was the theme that I can recall, and that has come up many a times over the years. But I do remember going to these meetings. I mean, in my head, I can visualize the building that I entered, and the room I sat in; but I can't remember the name of the organization that put the meeting together.

But I was, sort of, the designated Health Department representative onto that committee, to attend those meetings, and there were the mental health people there. And this -- I don't know if it was a collaborative or some other sort of group, but they were primarily people that dealt with substance abuse and mental health issues. And Public Health was invited to be a part of that discussion. Because, again, once things start to impact a lot more people, it becomes a Public Health issue.

Q. Is your understanding as to the cause for a rise in opioid use, a change from then to now?

A. I'm not sure I understand your question. Can you repeat that?

Q. Yeah.

We were discussing the early understanding during the 2011 to 2014 time period of what was perceived by Wayne County as a rise in opioid use. And there was a discussion of prescription opioids, theft from medicine cabinets as -- as what the community was seeing as a cause.

A. Right.

Q. Has that understanding changed, as you sit here today, in 2023?

A. Yes. A little bit.

So what I'm starting to see more -- and, again, this is all, sort of, anecdotal either listening to partners in meetings or just observing trends that we see in different reports and media stories and all that. There has been a lot more add-on burden now related to synthetic opioid like fentanyl.

But I believe for several years -- and I would venture to say for the first few years that I was aware of this topic, it was primarily discussion around prescription opioids. But over the last four or five years maybe, synthetic opioids have burst out to the scene and have been part of the conversation.

Q. Fair to say, synthetic opioids are more of a problem presently for Tarrant County than prescription opioids?

MS. AYACHI: Objection, form.

A. I don't know. I don't know. I don't have data to support one way or the other.

Q. (BY MR. CARDI) So what -- what supports your belief, as you sit here today, that synthetic is used and what you're hearing more about it, at least? That's what you said?

A. Yes.

So I'm hearing in different meetings from law enforcement partners and so forth that this has

become a new and major, emerging issues. And, also, I'm hearing the same kind of conversation from other health departments and different national meetings and conferences that I attend that as if it was not bad enough to have prescription opioids to be a problem, now we are facing synthetic opioids bursting onto the scene illegally adding to the problem.

Q. You began as public health director of Tarrant County Health Department in 2014; is that accurate?

A. That is correct.

Q. And you are presently the director of Public Health in Tarrant County?

A. Yes, that is correct.

Q. Have your responsibilities changed over the past ten years?

A. No. Just flavor de jure, right? {Phonetic.} You know, COVID came, and that was kind of unusual; but, no, it's the same. The main job is to be the administrator over the Health Department to oversee the daily operations.

Q. Has the structure of the Health Department changed over the past ten years?

A. A little bit.

Just sort of internal reorganization as we added more staff. But nothing that -- you know, it's

not a substantive change that we suddenly are doing a lot more different things or anything like that. It's just we added more people. They have some more specialties. So we kind of reorganized to make sure they're a better fit. That's all.

Q. What positions have been added over the past ten years?

A. So COVID added a lot of stuff, a lot of positions; but primary focus was adding a lot more epidemiologists, a lot of infomatics people.

Usually -- they kind of grew out of epidemiology. So, like, how I was an epidemiologist, but I, kind of, got sucked into electronic data systems and working with IT on back end, the data collection, making sure everything worked smoothly. That discipline grew out over the last of couple decades into public health infomatics. So now we have a whole infomatics division.

And then we added a call center. Public Health never had that, but now we have people that actually take phone calls to -- in a centralized way to answer a lot of general questions. Used to be, people would just call and get right to the program or get right to the clinic. Now, we have a call center that actually, sort of, Level 1 customer support. They

answer frequently asked questions. And then if it gets complicated, then they go back to the program because that way the programs have more time to actually deal with their job versus just answering phone calls.

And then we added some clinic staff for vaccination purposes and testing purposes. And we added some health educators who go out into the community and talk about vaccines and all those type of things or other public health issues.

So a lot of that is COVID-funding driven, increases in capacity that we are currently slowing dwindling down as COVID recedes.

Q. Has the staff expansion of the past ten years been driven in any way by substance abuse?

A. No.

And not for the -- the lack of perceived need by us. We have been trying to add. Public Health, unfortunately, is very driven by grant funding.

So just to give you a perspective, we got about $135 million of total budget. Majority of that is various grant funds over 50 to 55 different grants that come with stipulations on what you're supposed to do. And local money is only about 12, $13 million, so about 10 percent of our funding. So there's not a funding source currently that is big enough.

We had, like, one tiny grant from New York City Health Department that mentions opioids and, yes, start to work on your syndromic surveillance system to start looking at trends in your opioid data. But other than that, we have not been successful in getting direct funding to add capacity to study opioid issues or add staff related to opioid issues. A lot of SAMHSA funding, being the structure in Texas, goes to entities like MHMR. So we don't end up getting moneys to add capacity unfortunately.

Q. You said 10 percent of the budget comes from local sources; is that accurate?

A. That is correct, yes.

Q. And how do you define local?

A. So in most communities, they would call it general fund. But in Tarrant County, we have a unique structure. Public Health Department does not get general fund at all.

Many years ago -- we have a public health hospital or like a hospital district. It's the county organization, but they have their own taxing authority on the tax line. So Hospital District gets some tax dollars and a lot of other revenue that they generate through various grants and billing insurances and Medicaid and Medicare and so forth. And we're just one

cost center on the Hospital District funding. So, essentially, we've got a mix of revenue. That doesn't necessarily mean you've got local money or not.

But we get our money from Hospital District. But that is equivalent to what you would assume is local dollars. Like if we were to get direct money from the county as general fund, they would probably give us similar amounts, right? So it's kind of a roundabout way, okay, you're going to fund Public Health.

So it's kind of -- some countries in Texas have that where they get their moneys from the Hospital District because the county create {sic}. Hey, this is the health district, and y'all figure out how to split the pot.

Q. So local sources of funds, you're speaking of county funds?

A. Yes.

Hospital Districts funds. So I don't get any direct moneys from the county. I get the local contribution is Hospital District funds. Hospital District is a county entity authorized by the county, and they're given the authority to put a tax line on the local property taxes.

So do I get some? Probably. But it's hard

to say because taxes make a small portion, probably one-third of their revenue.

Q. Okay. I think I understand.

So 10 percent of the Public Health budget comes through hospital districts --

A. Hospital districts.

Q. -- which --

A. Yeah.

Q. -- and those districts are funded from multiple sources including county funds. And so some, maybe small portion of that 10 percent, is -- is -- flows from the county through the districts to Public Health; is that...

A. Sort of. It doesn't necessarily flow from the county because the district is a taxing authority of its own.

Q. Sure.

A. So, yes, it's authorized by the county. So, essentially, the county says, yes, you can put a tax line on the tax bill; and that's your tax source, if you will. The revenue source. But it's authorized by the county. So, yes.

THE CERTIFIED STENOGRAPHER: Counsel, this is the court reporter. When you get to a stopping point, I'd like to take a break, please.

MR. CARDI: We can take a break now.

THE CERTIFIED STENOGRAPHER: Thank you.

THE VIDEOGRAPHER: We're off the record at 11:13 a.m.

(A break was taken from 11:13 a.m. to 11:30 a.m.)

THE VIDEOGRAPHER: We are back on the record at 11:31 a.m.

Q. (BY MR. CARDI) Dr. Taneja, how would you describe the mission of Tarrant County Public Health Department?

A. Sure.

So our mission is to really safeguard our community health and sort of improve the health in our community through leadership and health strategy.

Q. Okay.

What are your responsibilities as a director?

A. Generally, oversight of day-to-day operations. Majority of that is what I would call administration. Dealing with budgets, HR issues, hiring and the firing of people, you know, all those kind of boring things that administrators deal with.

But, also, being from a medical background and also being from an epidemiology background, I am the

spokesperson for the department also when there are large outbreak-related matters or Public Health emergent issues.

So good examples {sic} would be COVID. I was sort of the spokesperson. Were there other people from the department who talked to the media and the public? Absolutely. But I was kind of the face plastered all over the TV and media and all that.

But that's happening frequently. Ebola, Zika. Large county, lots of things happen.

Q. Understood.

You mentioned that there's been an increase in staff for the past ten years.

Well, what is the present dedicated staff member to Tarrant County Public Health?

A. About 537 filled positions the last I checked two or three weeks ago.

Q. Do you recall roughly what the number was when you began about ten years ago?

A. Yeah. About 330-ish.

In general terms, I'll tell you, Public Health Departments and county government here in Tarrant County is very conservative in hiring. So pre-COVID, I think over the course of maybe five, six years, we might have added maybe 10, 12 positions. We were about 340,

350 strong depending on what was going on.

And then during COVID, there was a lot of surge in capacity because the need was so great and a lot of different kinds of funding was coming into actually hire staff to deal with the issue. So we were able to almost, not quite double, but expand capacity significantly.

(Simultaneous cross-talk ensues.)

Q. (BY MR. CARDI) During the COVID period?

A. Yeah. It's mostly COVID related, yes.

Q. I believe you said that the budget is roughly 150 million?

A. 135-ish.

Q. 35?

A. Yeah. Uh-huh.

Q. Has it similarly grown over the past ten years and particularly during COVID?

A. Yes.

I think when I first joined, it was probably right around 50 million. I mean, I don't have the exact, but it was -- it was not very big.

And then pre-COVID, we were in the 70 million range. I think maybe 72 million. And then it almost, not quite doubled, but close to during COVID due to various grant funds that came in.

Q. Has the percentage of the budget funded from local sources shifted during the past ten years?

A. No.

Generally, that has remained pretty stable. This year, we did not get a year-over-year increase; but, generally, it's about a 3 percent increase year over year. Adds to about, maybe 250 to $300,000 because the 3 percent is usually, like, on salary expenses, not the entire budget. So not a very significant increase year over year, and that's been the trend pretty consistently over the last ten years.

Q. The budget has grown significantly. And as I gather, that's largely due to -- to grant sources outside of local government.

Has the local government funding then similarly increased if it's remained at ten percent? I'm just trying to understand.

A. So it has not increased.

Q. Okay.

A. The only year-over-year increase has been about 3 percent on salary expenses that are funded by that local pot of money.

So, like I said, every year ballpark 250 to $300,000 increase on the local budget. From a percentage basis relative to our entire budget, it has

actually shrunk because we have a lot more grant funds, a bigger budget. So the local dollars look smaller.

Q. I understand.

And local dollars, just to confirm, is about ten percent?

A. Right now, yes.

Because they're about 13-ish million -- little bit maybe. Somewhere in that range. It's not exact but about 13 million.

Q. And the rest of the budget is it entirely grant?

A. No.

Grants make up majority of the budget, but some revenues are generated through health department billing for clinical services, and some fees we collect for environmental health; restaurant inspections; some fines that are levied on people that let their apartments expire and things like that. An occasional, you know, few thousand here and there; some donations. You know, somebody who likes to donate some money. Hey, help do this good thing in your community. Here's some donation.

So it's a mix of a lot of things, but generally majority of it is grant funds from various sources. Most of them are passthrough funds through the

state government, Department of State Health Services receives moneys from the CDC, and they pass it onto local departments in the state.

But, lately, some have been direct funding opportunities from the federal government. And then other than grants, there are some other programs that are revenue reimbursement. There are cost-reimbursement programs from beyond the scope, you know. One you might find interesting is 340B drug reimbursement program but it's for us related to TB is HIV is STD medications.

Q. Roughly 1 percent of the budget is funded from the grant sources?

A. I would venture to say almost 80 percent. They make the majority of our budget.

Q. And that percentage has increased since COVID -- during and since COVID?

A. Yes.

Q. Okay.

A. It significantly increased during COVID time frame.

Q. Are certain grants geared towards research specifically?

A. Not for us.

A lot of the research grants are more to like academic institutions or hospitals that are tied to

academic institutions and so forth. Generally, the health departments don't have a research component and we participate. Sometimes there's opportunities. But I don't recall anything recently where we've gotten a research grant at all.

Q. Stimulus grants? Are those received by Tarrant County Public Health?

A. So not by the health department directly but, for example, CARES funding came and then the ARPA funding came. And then, again, I don't know how you define stimulus payments, but general public understands these were stimulus payments. So that's my understanding.

But we did get some money from the county from CARES funds and some ARPA funds to do some of the work we were doing related to COVID and just building capacity in the department. And those were -- I would venture to say there were stimulus payments, but I don't know what your definition is.

Q. Does the Public Health Department -- has it ever received grants specific to addressing substance abuse?

A. So the one grant I can recall is the New York City Health Department gave us some passthrough funding, a couple hundred thousand dollars. And I don't exactly

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recall the time frame 2019, maybe early 2020.
And we -- we had actually applied for a grant to the CDC and didn't succeed. And New York City -- we were in conversation with a large group of health departments, and they said, well, we can give you some extra money we have. Get your work started on observing trends in the data in your ERs.
And so we got the moneys. And then COVID hit. And it kind of sat to the aside for a little bit until we were able to sort of use that to support our syndromic surveillance data and looking at some of that data. But that's the only one I recall specifically related to either substance abuse or opioids.
Other than that, like I explained earlier, there's other entities in Tarrant County that are lead, and a lot of the funding that come from SAMHSA ends up in the pots related to MHMR and other related substance abuse entities in Tarrant County.
Q. Was the one grant you can recall was a one-off in early 2020?
A. Correct.
Q. And I believe you said it was -- it was applied to the SS analysis?
(Simultaneous cross-talk ensues.)
A. Yeah, the NSSP platform.

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I mean, the grant had other thing that we were supposed to get started, but then COVID really took away our capacity to do other things. So like I said, it kind of sat in a pot for a while without being utilized.
And as COVID start to do recede, we started to use the funds to support our Syndromic Surveillance System and started building the data queries and algorithms to start looking at what's happening with opioids in our ERs and so forth -- with drug overdoses in general, I think.
Q. (BY MR. CARDI) How did the fund support -- the syndromic surveillance program? Is it man hours we're speaking of? Is it software?
A. I'd have to go look, but I believe we paid for a software contract or part of that. I think they were switching from being a software that's supported by our IT on their infrastructure to a third-party company that was going to take it into the Cloud or things like that. Again, this is just going off of memory. So I'm not being 100 percent accurate on this. But I think we paid for part of that contract through those funds so that it could remain a viable system.
Q. Okay.
When you mentioned other initiatives that

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were derailed with COVID -- or by COVID, do you recall what those initiatives were?
A. So we were pretty aggressively pursuing a grant opportunity with the CDC regarding studying opioids and putting prevention strategies into our community because we were starting to see a growing trend in Tarrant County through various sources that we discussed earlier, and we did not succeed. And, you know, there's a lot of back and forth between us between CDC. And we disagreed; they disagreed on a lot of things.
So our thought was to pursue other opportunities. So we did succeed with New York City. We were trying to -- some other health department-style coalitions to secure funding because others did succeed in getting funding. And then COVID came, and we sort of put the efforts on back burner.
And, now, just recently, a grant opportunity just opened again with the CDC. So we've applied again to start getting some funding so we can start looking at this more in detail, and we're waiting on results back whether we will get the moneys or not.
Q. Do you recall any of the specific reasons that the Public Health Department did not get that CDC grant?
A. Yes.
So CDC kind of put out -- what they call a

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NOFO, notice of funding opportunity, and they had kind of named some areas in the country they believed were right for prevention-related work for opioids. Because they were seeing a rising trend of opioid-related issues in those communities. And Tarrant County was named as one of them.
And IN just conversations, we knew that we were there. But when we presented our data, they said, oops, we made an error in calculation.
And it kind of goes back to, oh, looking at Fort Worth as a city and their data, and then later realizing that the Health Department actually serves the entire county, and the jurisdiction's bigger.
And the data somewhat sometimes gets diluted because not every issue is evenly distributed in every corner of the county. Larger cities due tend to have large problems. So they kind of misunderstand the data, I believe.
And they looked at Fort Worth data, and the rates were high. But when they looked at us as a county health department and recalculated as a county, they were like, yeah, you don't qualify. And we argued that Fort Worth is part of the county, and there's a problem; let us get the money, get the work started to prevent it. And they disagreed.

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And we were not the only one. Harris County, which is Houston area -- Houston has a health department. They got funding. Harris County did not.

San Antonio/Bexar County Health department -- that's the county health department. They were in the same boat.

So there were very many upset health departments because they were invited in the opportunity, and then told, no. Sorry. We miscalculated, and you're not qualified.

So, now, in the second round of funding, we are, we believe, qualified because the rates have grown. We have data to show and all that; and we're waiting to see if they agree.

Q. Okay.

You mentioned prevention strategies and maybe research initiatives that you all were hoping to fund with the CDC grant. It was not awarded.

Do you have any further details on what those strategies were and plans were?

A. So no research initiatives as far as I can recall.

Q. Okay.

A. But prevention strategies -- I mean, generally -- and, again, I don't recall the specifics because it's

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been more than three to four years. But mostly it starts with public education. Raising the awareness about the issue, talking to various stakeholders to see what they're doing, and how the Health Department can educate the public.

One of the things that has happened in many communities is Narcan became available, and it -- you know, came through various routes. Like in our community, the sheriff's department carries it; the Medstar, the ambulance company carries it; and a few other different police departments carry it.

But there's not been a health-department-concerted effort to raise the awareness about Narcan use and how people can use it and, you know, where you can go get it because we did not have the moneys to put towards that effort.

I'll give you other health department examples. Boston, I think, for example, was very focused. The health department was the lead in Narcan distribution and getting that adopted in the community.

The health director there -- they have a different staff. Their health officer, she's an M.D., and she wrote a citywide prescription for Narcan. So that anybody that ends up in an opioid-overdose situation can get Narcan.

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And this is before laws came into effect where you could just go get it from a pharmaceutical. So this was three or four years ago.

So a variety of different things could be done by health departments if we were given the funding and the opportunity to do so.

Q. Are these same initiatives the basis for the present requests to CDC for funds?

A. No.

Because a lot of those things are changed, right? So, like I mentioned, there's some state laws that came into effect and other laws where Narcan is now easily available at pharmacies. So, I mean, strategies would change.

Once we get the funding, maybe we don't need to write an order for everybody to get one, but we may raise more public awareness, you know. Do more educational campaigns on how to properly use it, when to properly use it. And if it doesn't work, how to reach help, how to connect to existing resources in the community.

And there's a -- and, again, staff would have more detail. This is just kind of scratching the service on how prevention strategies are usually crafted. But, again, the goal is to prevent the problem

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from happening. So that's, you know, early prevention, primary prevention.

And the other aspect would be more detailed. Like after somebody's hooked onto, you know, any substances, how do we get them, you know, early diagnosed and into care so they can get over their addiction? Those are usually what I would call secondary strategies and so forth. We're getting them into early treatment and addiction care, working with other community partner agencies. And health departments usually do very well in connecting people to care.

Q. What was the prior CDC grant applied for?

A. I believe the round came out in 2019-ish. Again, I'm just going by memory, but ballpark in that time frame.

Q. And so if I'm understanding you correctly, the intended use at that time was for prevention strategies, and you recall --

(Simultaneous cross-talk ensues.)

Q. (BY MR. CARDI) And you recall it being -- your examples were education and Narcan education.

Is there anything else specifically you can recall as being an intended use?

A. I can't recall.

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But, I mean, like I said, I'm not always the expert writing these grant opportunities. I have staff that are very entrenched, and they study the subject and what's being done by other health departments. So I'm sure they have a lot more detail that they probably presented in the grant opportunity or had in our strategy playbook on if we get the grant what are we going to do with it? Usually they require you to commit a work plan. But, you know, we did not succeed. So, now, if we do succeed, the strategies are probably going to be different looking at the current situation.

Q. Who, during the round three years ago, would have been that person knowledgeable of the intended use of the funds within the health department?

A. Yeah, so, I mean, one person comes to mind is my associate director, Dr. Tal Holmes -- Talmage Holmes. I believe he was the primary author of the grant packet, and he's still the primary author of the submission that we just did three or four months ago. I can't recall exactly, but this year in 2023. And we're waiting on hearing back from CDC.

Q. So Talmage Holmes would be the individual knowledgeable of the intended use of the present target funds?

A. Yes.

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Q. You spoke -- to your knowledge, the present request would be for also prevention strategies and what you called secondary strategies.

Any further detail that you can provide? I understand that Talmage Holmes may be person to speak with. But anything else that you are aware of?

A. Yeah, I mean, the two main things even before prevention is actually surveillance of the data, right? Collecting more data and understanding what the situation is in our community, where is it happening, you know. It's probably not evenly distributed everywhere in the county. Just like with any other disease, it's never, ever evenly distributed. There's pockets that are heavy, and there's pockets that are light.

So collecting all of that data, putting that all into sort of an understanding situational awareness, and then drafting strategies on what will work well in this part of the county and how do we do a prevention strategy -- we won't be alone. It will probably include medical examiner and law enforcement and MHMR, all of the substance abuse and mental health players in the community that already do the work in this arena. We would just be another prevention angle.

Because a lot of times, law enforcement's

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going to come in from a law enforcement angle. They want to make sure that any illicit drug use is being curbed, the networks of distribution are being stopped, and so forth, right? They don't necessarily delve into the health impacts and how to people prevent people from getting hooked on. So we'll come in with a prevention angle.

Same thing, you know, substance abuse providers and mental health entities are approaching it from that angle. A lot of times getting people into addiction care and treatment, not necessarily prevention. So we'll come in with a prevention angle.

Q. Right.

How would the dollars be actually implemented? Would it be likely manpower if you know? Or -- or what?

A. I don't recall the exact work plan details. But probably, you know, because usually these are not very big amounts of the dollars. We might hire like one staff. An example would be an epidemiologist focused on studying the data and collecting the data, and maybe an infomatics person visualizing everything.

And the rest of that would probably be implemented into programming with community partners. So getting prevention messages out, getting educational

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materials made and campaigns made and raising awareness, and then using existing resources. Because we have health educators and other staff that can be trained to do the work, but a lot of time money is spent in developing the material that goes into it.

So it depends on how big of a dollar amount we get. But as I recall when we were submitting the package, it wasn't very staff heavy. It was more like let's put the money out into the community, do the actual work.

But I believe there were going to be either one or two people, if we succeed, that are going to be dedicated to the grant.

Q. One or two people including an epidemiologist that would be focusing on prevention data, supporting prevention strategies in relation to substance abuse.

Is that what we're speaking of?

A. Correct.

Q. And is it tied to substance abuse generally or opioid abuse specifically?

A. I don't recall.

I believe it was opioid focused, but I'm sure we will be looking at poly substances because the data sets come together a lot of times. So I'm sure they'll be collecting more than just opioid-related

data, but I can't be 100 percent certain what was put into the work plan. Been a while.

Q. Sure.

When was the work plan submitted?

A. Memory doesn't support me but three, four months ago. Three months, something like that. Because I know the grant opportunity came this year, and there was a lot of activity within the department -- collecting information, putting it into package, and submitting it to the CDC. Tal Holmes was the primary author, and, of course, he worked with different staff to pull different pieces together. He might have more accurate time line on when it was submitted but three months ago roughly.

Q. Are there any at present positions within Tarrant County Public Health focused on substance abuse?

A. Not specifically.

But -- excuse me. For example, Micky Moerbe, our biostatistician, does get requests from time to time from Tal or other people who maybe going to a meeting or, you know, going to a conference and the opioid topic's coming up; and they want to understand about it.

Or the community may have a university partner or some organization may have sent the request

saying, Hey, can you look at a county-wide what's happening with this data? So she probably has pulled some reports. Hold on one second, please. Sorry.

And then I am not certain, but I know that the injury-prevention epidemiologist -- we did show her a couple of opportunities related to opioids and substance abuse. I think her attraction to opioid prevention has been more like related to heat injuries and traffic accidents and gun violence and all those type of things.

So sometimes people don't always, you know, get attracted to the topic. Yeah, "this is part of the job, but that's not my favorite kind of" thing. So I haven't seen a lot of reports at least coming out of her, but I can't be certain because she does report to the biostatistician Micky Moerbe. So I'm sure they're working together. I just haven't seen -- out of her email, it comes from Micky Moerbe and things like that. So I always assume, it's Micky and her team working on it.

Q. So as I understand it, at present, there are not any staff positions that -- who's primary focus is substance abuse or abused.

What about during the past ten years? Can you recall any position being -- having that primary

focused?

A. No.

And, again, simple reason, we've never had funding for it. And, like I said, the structure here is MHMR are the lead entities, and then there's other entities like Medstar, the ambulance company. And I don't know if they get any funding or not, but they're just kind of sucked in because they get calls. So we've never received any money to resources to work this, and that's why we haven't been able to.

Q. Well, okay.

You're also saying that it's -- there are other departments, I believe, who focus on that in a more primary way; is that accurate?

A. That's right.

And they're -- they're a quasi-governmental entity. They're not necessarily a county operation, but MHMR, My Health My Resource, they're authorized under state law, and they're a pretty decent-sized department, if you will, an organization.

And whenever we talk about opioid substance abuse, mental health issues -- because a lot of that gets combined in the same umbrella -- they are usually the lead entity, but there's other entities. Like there's Cook Children's Hospital that deals with mostly

children. They're a children's hospital. But they have an adverse childhood events task force.

And in those conversation, I've also heard about drug use and opioids and early childhood trauma and how that drives people into addiction. So, I mean, it's -- it's a widespread topic in many, many, many circles, and everybody is trying to work on that. Some more than the others.

Q. Given Public Health's mission and its broad mission, is it fair to say that Public Health would never strive to be a leader within the community in addressing these issues?

MS. AYACHI: Objection, form.

A. So -- yeah, it depends on the community. Let me give you an example. So New York City, for example, it's the Department of Health and Mental Hygiene. Long term from long time ago. And they have the mental health umbrella under the health department. They're a very large entity; and that's how the structure was; and that's how they're retained.

Wayne County, example, they were under Health and Human Services. So public health, mental health work together, and then mental health spun off into a large mental health authority; and the substance abuse umbrella kind of moved over.

In Tarrant County, the health department is very focused on physical health. Funding is very focused on physical health. Mental health substance abuse resources exist in the community.

And under our essential functions in public health, we step in if there's nobody else doing the work in the community. That's just how public health is everywhere. But if there is other people, we assure that they can do the work. We tie together the resources. We bring them to the table. If there's partners, nonprofit organizations, governmental entities, law enforcement, school district -- they're doing their things, but they're not working together. A lot of times we bring them together. So we're the coordinator of efforts, not necessarily the doer of effort. So that's where we see our role.

Even if we get grant opportunities, most people ask us for data. So we would look at surveillance; pass the information; gather it from medical examiner, law enforcement, ambulance companies. Put it all together in a composite picture. Here's what's happening in the community. Here's where the resources are. How can we work together to solve this?

And the prevention part will be the strategies that we might share. Here is our idea. What

do you think? Is it going to work? How do we make this work?

So that's how I see the role, not necessarily as a lead entity, but more like a glue that brings everybody together.

Q. (BY MR. CARDI) So increasing funding would serve that function as -- as coordinating the efforts of others as the primary doers and increasing surveillance?

A. That's right, yes.

Q. Okay. Okay.

We spoke of staff dedicated to substance use and abuse.

What about any programs or initiatives managed by Public Health? Are there presently any focused on substance use and abuse?

A. No. Not that I can recall.

I mean, there might be some handouts or materials that we might distribute here and there. Like Narcan when it came out, I'm sure we got packets of information from different organizations. Hey, help spread the word. But nothing that I can specifically recall that hit my radar that this is something we're doing very specifically to address this issue.

Q. And same answer looking back over the past ten years?

A. That is correct, yes.

Again, and it's all driven by lack of funding and the structure. We're not usually the first entity that people think of. Money goes the other way.

Q. Right.

You're not the first entity that people think of, but, also as you've said, that's not Public health-specific role, correct?

A. Not here in Tarrant County. That is correct.

Q. Okay.

Is there an overall organizational structure of Public Health?

A. Yes, we have an org chart. It's on our website. Or if you need it, I'm sure we can submit that to y'all.

Q. How many individuals report to you?

A. Direct reports, about eight or nine. And then indirect, obviously, the entire department, 537.

Q. Direct reports, can we go down their positions to the extent you can --

A. Sure.

Q. -- recall the eight or nine?

A. Sure. Absolutely.

So I have my medical director and local health authority, Dr. Catherine Colquitt. So if you

were to, kind of, think about hospital terms, a lot of people watch TV, and they understand that and organizations. So I'm the CEO of the organization.

She's the chief medical officer, right? So any medical orders that are written are under her signature and under her authority. So the clinical operations operate under her authority. I'm the administrative boss, if you will. And she's the medical boss, if you will.

And then I have the deputy director, right? So that's Angie Hagy. So she's my deputy director that helps me oversee the operation.

And then I have five, currently, associate directors. Dr. Tal Holmes is one of them. He's over disease-control area that is mostly epidemiology and laboratory function.

Then I have Catherine Andler. She's over all our backend office like fiscal finance, grants, and contracts. So all the buildings, facilities, all that fun stuff.

Then I have Sabrina Vidaurri. So she's another associate director. She's over what we call Health Protection and Response, but mostly it's environmental health -- restaurant inspections, food trucks, swimming pools, all those type of things. Also,

preparedness efforts -- planning related to, you know, any manmade or natural disasters including large outbreaks.

And then I have Dr. J'Vonnah Maryman. She's over our family health services. So that's all of our maternal, child health-style programs. Anything that touches moms and babies like the WIC program or nurse-family partnership. That's home-visiting program. So there's many of those.

And then Dr. Gary Kesling, who's over our clinical operation. So he works very closely with Dr. Colquitt. So Dr. Colquitt's the medical director and also a clinician. So she's a doctor in one of our clinics.

But he's sort of the administrative overhead guy. Like, you know, I'm not always there to deal with all the managers and all those issues in the clinics, and he's the person who day to day makes sure that the clinics run smoothly, which one's opening/closing due to staffing issue, or they have an event, or somebody needs to take time off, and they're in the management team, so they go to Dr. Kesling.

So it's kind of a layered structure like in any large organization, but the associate directors help manage the middle and front management; and I'm at the

-- sort of the executive level, if you will, with Dr. Colquitt and Angie Hagy.

Q. And who do you report to?

A. To the county administrator, Mr. G.K. Maenius.

Q. Okay.

Is substance abuse one of the primary concerns of Public Health Department?

A. It's a growing concern. Not primary. A lot of things that we are dealing with are related to chronic diseases right now -- obesity, diabetes.

In our community health needs assessment, mental health, which is a big umbrella, includes substance abuse -- has come up to a top priority even ahead of chronic diseases. So I wouldn't say that substance abuse was, like, the number one priority, but it's in that umbrella that's risen to the top.

But mental health is a sort of a broad subject. So -- and we're not the only ones seeing it. The Hospital District is doing their own needs assessment, and they've had some done in the past. And mental health capacity, substance abuse issues, they've all been brought up in the past as needs.

But in our case, mental health, as a broad topic, came up number one; and chronic disease is number two. And there's a couple more, but those are really

the top two.

Q. Has mental health always been a top-related concern?

A. Yeah, I don't recall exactly. I think those change.

But I will tell you generally, you know, when we do needs assessment, mental health is not absent by any means. It's always been in, like, major concerns, but I don't know if they've been top one, two, three. I mean, I don't remember from previous years to now.

But the recent assessment that is not yet fully done -- but just looking at the trends, it has been rising up to the top that -- and no secret. A lot of people have been talking about mental health after COVID. So it is not surprised {sic} that everybody is kind of stressed out and dealing with issues.

Q. Okay.

Is it fair to say the substance abuse is -- has not been identified by the county as one of the primary causes for the increase in mental health needs?

MS. AYACHI: Objection, form.

A. Not that I can -- yeah, not that I can tell you right now because I haven't looked at the final data; but, again, that's just -- reports are pending.

Q. (BY MR. CARDI) I mean, as you sit here today, what do you believe is the primary cause in the increase of mental health needs in Tarrant County?

A. I couldn't tell you accurately. I'd have to look at the data.

But just being in public health, I can tell you that mental health issues have been in -- on an increasing trend over the last few years, and it's not an unusual trend. I mean, we're seeing that all across the country.

I've always heard -- and, again, I don't have data to show or support that, but it makes logical sense that COVID was a big stressor all across the world including in our community. And that has increased to people getting isolated, losing access to community, and just stresses of life have increased over the last few years that's added to mental health pressures.

I also just learned being in different circles, there's anecdotal conversations that I am privy to that it has also increased substance abuse because people were home isolated. They found medicine; took it. But, again, I don't have any concrete data today that I can share with you that supports that, but it's buzz in the community and in our public health circles.

Q. Anecdotally, mental health has been viewed as a

potential cause of increased substance abuse; is that what you're saying?

A. I don't know that one is -- I don't know how to characterize that. I really don't.

I mean, whether mental health issues are the cause of substance abuse increase or substance abuse causing mental health issues? I don't know. It can go either way. And a lot of resources would have to be spent to, kind of, understand.

But I think they're tied. We usually see people with addiction -- alcoholism, tobacco use, you know, prescription drug use, illicit drug use -- it's a continuum. Like one can be a gateway to the others. And a lot of times, there are triggers for mental health issues. And a lot of times, people with mental health issues end up falling to addiction. So it's, kind, of a two-way street there.

Q. Fair to say, it's, as a matter of human nature, mental health and a decrease in mental health has always turned human beings to abusive substances, whether it's alcohol, tobacco, meth, opioids, whatever -- whatever is out there; is that fair?

MS. AYACHI: Objection, form.

A. Yeah, I can't speculate on that unfortunately.

Q. (BY MR. CARDI) You don't have an opinion on

that, Doctor?

A. I don't.

Q. Okay.

A. I don't. I mean, like I said, it goes both ways.

Q. Right.

But speaking of that direction, being those with mental health problems turning to substances whether opioids, methamphetamines, alcohol -- you can't speak to whether or not, there's a connection and there always has been?

MS. AYACHI: Objection, form.

A. (No response.)

Q. (BY MR. CARDI) Doctor?

A. Like I said, it goes both way.

Q. So you would agree that it has always gone that way? Mental health leading to abusing --

A. What I'm --

(Simultaneous cross-talk ensues.)

Q. (BY MR. CARDI) -- substances?

A. Yeah, what I'm saying is, one, I don't have data to accurately answer that. I'm sure there's been research done. I'm not a mental health or substance abuse expert. So, first, I would defer you to them for that opinion.

But, secondly, what I know just being in the health world 20-plus years, it goes both ways. It's not that one is the cause of the other, or the other is the cause of -- I mean, I've kind of learn that both can lead to each other. They usually work hand in hand, right?

And let me give you an alternate example. Totally different. So HIV disease in itself can happen on its own. Syphilis is a disease in itself can happen on it's own. What we observe is a lot of times, they both happen together. And one can lead to the other happening faster, sooner, at a higher pace in individuals; and they end up with both.

Same thing, a lot of diseases work together. So addictions can lead to mental health issues. Mental health issues can lead to addiction issues. I am not the expert to say the main driver of one or the other. You're asking the wrong person unfortunately.

Q. Well, I wasn't asking which ones -- which direction is the main driver of the other. I was just asking if you agreed that there always has been a connection between mental health an substance abuse no matter the substance, any substance that can be abused. That was my question, doctor.

And you don't have an opinion?

A. I've given you my answer.

Q. Okay.

A. I've given you my answer. My opinion has not changed.

Q. Who maintains the Tarrant County website -- Tarrant County Public Health website?

A. Yeah, so the technical aspects are maintained by the county IT department.

Content comes from the Health Department staff. Different programs. And we have layers of mechanisms.

We have a public information office, and they look at grammar and presentation and pictures and make sure it's accurately posting on the website. But the subject matter comes from our staff. And, usually, that's, you know, paraphrased and copied from other resources like the CDC and DSHS.

But, usually, it's not a lot of time a whole lot of original content on its own because the message is supposed to be unified, right? We're all working on the same things. So we might have a different flare, and maybe, you know, put up a more relevant topic in front of the public in our community. But, generally, we're not usually the original content

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authors. It's borrowed from public sector locations like CDC and the Department of State Health Services.
Q. How often is the content updated?
A. We're supposed to keep it fairly updated, but it's -- it's an ongoing process, and we ebb and flow.
Like when COVID came, a lot of the focus was shifted on keeping COVID content updated pretty much day to day. But that also meant that a lot of other content went stale.
But, now, there's been concerted efforts trying to get everybody back on board and looking at their program information. As staff kind of settled back into their normal operations and starting -- we're starting to update the website again on a -- on a more frequent basis.
I know that my deputy director and our PIO has monthly meetings set up with different groups within the department who go over the website and its content, and they're working on cutting out things that are are old or outdated; photos that look dated, if you will; and bringing new content; or, at least, have a fresh look that it's been reviewed and updated and so forth.
Q. There is a page titled, "Current Concerns" under Public Health.
What is the purpose of that page and the

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content?
(Simultaneous cross-talk ensues.)
A. Yeah, so the idea is to give people a quick landing page to see what are the top, emerging health issues in Tarrant County. So lot of that was, like, driven by COVID. People wanted to know like where do I go to find what are the top, major issues that the Health Department's dealing with or our community is dealing with? Like COVID, monkeypox, West Nile came, things like that. Other topics come and go and it's -- that's what it is.
Q. (BY MR. CARDI) There's my screen there.
A. Yeah.
Q. Are you able to see it?
A. Yeah.
Q. Is this the Tarrant County Public Health "Current Concerns" page?
A. That is correct, yes.
Q. And the items listed are (as read): "Avoid heat injuries, director's blog entry, rolling through August, be AQI aware of West Nile virus, testing for sexually transmitted infections, and COVID-19 and its variants"; is that accurate?
A. Yes.
Q. And it looks like it was last modified

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August 22, 2023?
A. Yes, that is correct.
Q. Is this page updated, changed on any planned schedule; or is it just as the concerns shift?
A. Yeah, usually as the concerns shift.
And just for context, a lot of this is also driven by, sort of, media inquiries and topics that they're asking. So we put those current concerns in an easy-to-find page sort of to reduce phone calls and repeatedly similar questions. Because then they kind of get mad. Like, hey, drop everything; do an interview. And we're, like, no. Just go here. Pick your information. Run your story.
So just to give you context, so on our health needs assessment are going to methodically, sort of, determined health needs of the community versus these current concerns are more topical things that we're getting called about either from the public or from the media, and it's just for easy access. And are they issues that are emerging in the community? Like heat. We had 100-plus degree days for several days in a row. So, yeah, is heat injury, you know, a current concern? Absolutely it is. Does it rise to the top of the pile of what's impacting Tarrant County? No.
Same thing I mentioned. What is the big

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health concern that's on top of my mind? Chronic diseases.
You don't see that here because nobody's asking about it. Nobody cares about it and -- but we know working in the community, looking at the data, that is a primary driver of health issues. So people are getting obese. They're getting diabetes. They're getting heart disease.
Once that data is ready to publish, we'll probably have a discussion saying, hey, should we put this on? Then we'll look at analytics. Hey, is anybody even looking at it? If they're not, take it off. We'll keep working in the public health circles and in the health circles with the hospitals and so forth.
But a lot of this page is driven by what we get frequently asked questions from the public through our call center and through the media.
Q. The topics are presented here, and it says (as read): "The listing below touches on immediate and growing health concerns we see in Tarrant County."
Did I read that accurately?
A. Yeah.
Q. And when you say (as read): "We see," you're referring to public health? And by public health seeing these topics, you're saying it's coming through phone

calls, not really from data?
A. Yeah, some of that is through data.
I mean, of course, we do injury -- or heat surveillance, and we do, you know, West Nile, and vector-borne disease surveillance. But a lot of these topics are seasonal also. Every year in the summertime, you're going to see a heat injury topic come up as a current concern. West Nile come up as a current concern, you know.
And there's years that are sort of light in West Nile, and years that are really heavy. But you're probably going to see this topic come back because it's a media-darling topic. You get calls incessantly about this topic.
So where we sort of, again, rest our our head on is what is the actual health issue by times and by community and community partners supported by data and all of that. Usually comes in a five-year cycle through something called the Community Health Assessment. I explained that to you earlier; that we do some data gathering and surveys and look at all the health indicators. So it's very methodical.
And then we listen to community partners in listening sessions. We then post that on the website for the public to make a comment like if they agree on

what we're seeing.
And, usually, that creates prioritization. That's where mental health was coming up as number one; chronic disease as number two. That is what is called Community Health Assessment.
And then later we work various community partners to create something called a Community Health Improvement Plan. How do we come together as a community and address these issues?
And there's a disconnect between this page and what is actually the real heavy-hitter health issues. Because, again, this page is more, you know, people call like, hey, you know, I heard there's West Nile. Where can I go? Oh, go to our current pages. You'll find it. You know, there's a director's blog, you know.
It's -- it's there, but it's there for a purpose to solve the problem of constantly getting phone calls while you're in meetings and trying to answer one-off questions from media and the public. And there it is. Go here. And usually that satisfies them.
But more scientific, accurate approach and really looking at holistic health of the community, that's on our Community Health Assessment done on almost a five-year basis.

Q. When is the last public health -- community health -- I'm sorry. Say it again. Community Public Health Assessment?
A. Yes.
So a published one was, I think, back in 2015. And the next one was supposed to be done in 2020, and then COVID came. So we started the assessment in '22, and then we're almost done.
I think it's going through sort of the final iterations of getting approved, and I think there's going to be a public comment period on that. So hopefully here in the next month or so, we'll publish the next iteration. It will be a 2022 version but published in '23. And, again, a lot of these indicators are, like, on a five-year cycle.
And the five-year cycle comes from our accreditation requirements. Hospitals have JCO requirements. They do it every three years.
So we did participate in the one with the Hospital District in 2000, I think. So they had one. I know they got delayed. They're doing theirs also now. And we're finding similar things. And they're not necessarily, you know, heat and West Nile because these are very topicular {sic} blips risks on the radar. Health assessments look at what is driving the health

problems in your community versus what are topics of the day. So a little bit different.
Q. What -- and I understand that it's a draft report that's in review, but do you have a knowledge as to what the focus areas are and the upcoming community Public Health Assessment?
A. Yeah.
And I don't recall all four. But I know there were four parties that were identified or major health issues. Number one was mental health; and number two was chronic, but I recall -- a block on the other two. But, again, because it's in draft and some of the prioritization changes when we finish the listening sessions and community comments. So I was like, okay, let that all settle, and then I'll, you know, "read it once it's ready" kind of thing, so...
Q. Mental health priority is not specific to substance use, correct?
A. Not that I can recall, but I'm sure it makes up a component of that mental health issue. Because, again, just knowing what we know, it is part of that, but it's mental health broadly.
And then -- oh, and then the other thing, I think, the -- and, now, I remember the other two. One was related to Medicare costs being high. And then the

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last one, I believe -- and I don't remember the order of the last two -- was related to primary care doctor access. So even though there's primary care doctors, they're not evenly distributed, and there's delays in accessing care. So those were the four -- mental health, chronic diseases, primary care access, and Medicare costs.

Q. Do you recall what the priorities were in 2015 Community Public Health Assessment?

A. I don't, but the assessment is on our website. So if you're on the website, I'm sure we can do a quick search and find it. Or just do a Google search, and it will bring up the PDF.

But I think one of the ones was related to education. Because at the time, it was being observed that a lot of our high school graduations were not happening. You know, some kids were -- or quite a lot of kids were dropping out and not completing high school.

And I'm sure -- memory fades, but there were -- chronic diseases were always there, and I'm sure there were other issues. But we can do a quick search, and it's on the website.

Q. Do you recall substance use or abuse ever being on the Current Concerns page?

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A. No, I don't. And, again, because it's never been our main area of expertise as the health department, so we don't put that out.

Q. But if many in the community have been calling asking questions, would that be the type of topic that would be on this Current Concerns page?

A. Yes.

If we were to start getting calls a lot on substance abuse issues and where is the data and how do we access this data, we would put that topic on the page. And the article or the details below the topic, when you click on it, would have access to any reports that we might have pulled together from different data sources, maybe a data brief that's been done on overdoses and substance abuse. And I'm sure we've done some of that. It's probably on our website somewhere.

So we would collate all of that information in an easy-to-find way. Because the website is big, and not everybody knows how to navigate.

So when they call the call center, usually you have a clerk answering the phone, and they're not knowledgeable of the topics either. So they know to send the public to the Current Concerns page, and then they look together with the person on the phone, and that's how mostly we answer the questions.

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Q. You --

MR. CARDI: Yes.

THE CERTIFIED STENOGRAPHER: Counsel, this is court reporter. Is now another good time for a break?

MR. CARDI: Yes, ma'am, that's fine.

THE CERTIFIED STENOGRAPHER: Thank you.

THE VIDEOGRAPHER: All right. We're off the record at 12:29 p.m.

(A break was taken from 12:30 p.m. to 12:44 p.m.)

THE VIDEOGRAPHER: We are back on the record at 12:44 p.m.

Q. (BY MR. CARDI) Dr. Taneja, do you hold yourself out to your peers as an expert in pain medicine?

A. No.

Q. Do you hold yourself out to your peers as an expert in addiction?

A. No.

Q. Have you received any training in pharmacy or pharmaceutical practices?

A. Other than, like, my medical school stuff learning about drugs and medicine, nothing specific related to, like, pharmacy; but I'm familiar with the

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drug classes and so forth.

Q. Okay.

You understand that pharmacists cannot prescribe medications, correct?

A. Correct.

And there's some nuances there; but, yes, yes. I mean, some law have allowed them to prescribe like Paxlovid, for example, for COVID and things like that. But, yes, generally they cannot prescribe medicine, yes.

Q. Pharmacists cannot prescribe opioid medications, correct?

A. Not fully aware.

I know they can dispense Narcan, but I'm not sure of the mechanism on how they can -- but, generally, yes, they are not typically the people that I would think would prescribe meds to the public. They just fulfill the doctor's orders.

Q. Do you know anything about how pharmacists are regulated?

A. State Pharmacy Board, I believe.

Q. But you're not an expert on how pharmacists are --

(Simultaneous cross-talk ensues.)

A. No.

Q. (BY MR. CARDI) Correct?
A. Not at all.
Q. And do you have any knowledge about pharmacists training -- the training the pharmacists receive to become trained pharmacists
A. Just a little bit. Just being in the health field.
I'm not an expert by any means, but I know they go to pharmacy school, and a lot of them have a Pharm.D. degree. When they actually become a full pharmacist, they have their little practice internship, if you will, and all those types of things.
But it's just outside view not -- I'm not in the pharmacy world, so I have no firsthand knowledge.
Q. Do you have any firsthand or specific knowledge about the licensing requirements for pharmacists?
A. No, I don't.
Q. Do you know under what circumstances a pharmacist should or should not fulfill a prescription?
A. I mean, doctor's orders. If there's a prescription and they have it. But, again, this is outside view.
I don't know if there's other criteria where they cannot fill. I mean, if there's a contraindication that they become aware of. I mean,

that's just common sense, right?
I mean, doctor said, give this person penicillin and the person says, I'm allergic. Well, don't fill it, right?
Q. Sure.
A. Yeah.
Q. Any other, I guess, lay knowledge on the contraindications, which would lead a pharmacist to not fill a prescription?
A. Talking about the opioid topic, I mean, if they're aware that this person's addicted, well, they shouldn't, right? But, again, that's just, kind of, a lay-knowledge answer.
Q. Do you have any knowledge of how a pharmacist would know or would not know a patient is addicted?
A. You know -- and, again, this is, kind of, very, you know, layman, kind of, conversation, speculative, so to speak. But, generally, my experience with pharmacists have been that they get to know their customer. Like my pharmacist knows me and my family by first name, and she remembers and she trains her staff, hey, if Vinny comes in, here's all the meds. Here's questions that you need to ask him, and here's things that he's already answered. Don't bother him. So, I mean, it becomes integral. Just like primary care doc,

they're a part of care.
But if I go to a different pharmacy, that relationship takes a while to establish. So I would assume that if I was repeatedly coming in to pick up medications that are, you know, habit forming, they would probably delve a little bit deeper into, hey, why do you need all of this stuff all the time? What's going on? I mean, they ask you. They say, hey. Like I went up and picked some medication. Oh, you got this? Yes, I did, you know...
Q. Are you speaking of -- of just the visual examination by the pharmacist of patients coming in, coupled with just the back and forth --
A. Yes.
Q. -- "get to know you" knowledge?
A. That's right.
Yeah, I mean, and that's how I've experienced pharmacists, but I'm sure there's, you know, different handling in different areas. But, fortunately, the people that I've worked with usually get to know me and my family, and that's just how -- it's been a pretty decent experience.
Q. And in your experience in being prescribed and obtaining prescriptions from pharmacists, fair to say, that pharmacists do not examine your need for

prescription the same way the physicians do, correct?
A. No, no.
They usually go over the instructions on the prescription. And are you taking other medications that may interact with this? They do ask about allergies and, you know, previous reactions. Have you had any problems? Have you used this medication in the past?
And so they go through some health history with you, but not to the level that a physician would. Because a physician's aware about your health condition, and they usually are the ones that diagnosed it or got into your care if you already had a preexisting condition and things like that.
But the pharmacist is more dealing, from my experience, with here's medication your doctor prescribed. Do you know how to properly use it? Here's things to watch for. And take it with food, without food; or, you know, you might nausea; you might get metallic taste in your mouth, whatever. Don't drive. It may make you sleepy. All that kind of stuff, you know.
Q. As director of the Tarrant County Public Health Department, do you believe there is presently a heroin crisis or epidemic in Tarrant County?

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A. I don't have any data to support that.
But anecdotal I know fentanyl has been making the news in Tarrant County quite a bit. In fact, I mentioned there was a billboard on the highway the other day that I saw. Fentanyl-related deaths, you know, on the rise in Tarrant County. Let's work together to address this. So I did see that.
Q. Other than, you know, a billboard on the highway, you don't recall having reviewed, I mean, data that your department has access to regarding the increase or decrease in the general existence of heroin and fentanyl-related overdoses?
A. So there is data. And my health department did put out a data brief. And it's been a while. So I don't necessarily recall exactly the details. But I know fentanyl-related deaths were mentioned.
And some of that data comes from medical examiners. Some comes from like CDC Wonder. And I think the data brief is more focused on overdose deaths in general, and it goes a little bit into, you know, what kind of substances are involved.
But it's been a while since I've reviewed that. And it was just whenever the biostatistician was putting that out that I looked at it. But nothing specifically that I can recall.

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Q. Given your recollection on the numbers, is it fair to say that it's not a specific concern of yours as director of the Tarrant County Public Health Department?
A. It's a growing concern.
But, like I said, COVID was a major priority for many health departments and many health directors. And a lot of these other things, even though we know -- it's kind of a -- sorry for the analogy -- but it's kind of like a slow-moving train wreck. You know, health -- things that really impact health are usually slow moving -- chronic diseases, substance abuse issues, violence issues. You know, trends that are moving your community's health outcome.
And then there are topics that just explode onto the scene. COVID came, or there's a West Nile heavy season or -- so they pick up a lot of time and resources and attention because they're very immediate topics. And sometimes it takes your energy away.
And we know that these things are on a trend. STDs are on a rise, right? You know, syphilis is on a rise, and it's been on a rise for years. And are there efforts going on to curb that? Absolutely. But is it, like, on an everyday top of mind that I got to solve this syphilis problem today? No. COVID happened. Let's deal with that today, right?

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So we're also people. We know things that are driving health outcomes, but then there's what we say, immediate let's put out this fire because we can do something about that, and the other things are going to take a while.
Q. You been speaking about heroin and fentanyl, which are illicit opioids at least typically as you see them, correct?
A. Yes, yes. That is correct.
Q. What forms the basis of your opinion that it is a growing concern of illicit opioids?
A. A couple of things I mentioned. We did see some data brief that my department put out, there were some, I guess, analysis from medical examiner data that there were, you know, illicit drug-related deaths that were increasing part of that Community Health Assessment.
Also, I believe there's a component in there, and there's a mental health priority area that -- and, again, I'm paraphrasing what my staff have told me that overdose deaths have increased almost by double. And, again, this is very generic since 2019.
Q. You said '19?
A. Yeah.
Because I remember this from a meeting that

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I attended a few days ago. And -- and it's, just kind of, a one-blitz conversation because it was a conversation between two different parties. I was kind of listening in on the conversation. And so -- and, again, I'm kind of waiting for the report to be finalized. So I look at the data and all those type of things.
But, again, it didn't surprise me. It's, like, yeah, I mean, that's what I'm hearing in other circles also. And I had just seen that billboard. So it was, like, yeah, this makes sense that our data is showing what I'm seeing on the billboard, what community partner organizations are talking about.
And, again, there are people in the department that are experts that do this on a very methodical, scientific basis. At administration level, you kind of get the end product like, okay, here's the key issue that's happening, and let's get together, make decisions, drive the resources to address that.
Q. Your recollection is that the data you have seen recently indicates that that overdose deaths have doubled since '19.
Is that overdoses by -- from all substances and all combination of substances?
A. I -- you know, again, I'm recalling from a

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meeting that I listened in to. So staff will have more accurate details on that, but I believe they mentioned overdose deaths from highly substances including fentanyl. Fentanyl -- fentanyl was brought up as an example.

Q. Okay.

Do you believe that alcohol abuse is a growing concern?

A. I don't have any recollection of any data that I've recently seen, but it hasn't hit my radar.

I know that like generally what we know is, you know, alcohol, tobacco use, all those type of things, they ebb and flow. For example, tobacco use is on a decline, and the e-cigarette use was on an increase, right?

I mean, but I haven't recently seen any data particularly for Tarrant County on alcohol use, but I'm sure my team has it. Because the staff who work in this area that -- the biostatistician, for example, they can pull out data briefs that they've done for any requests that may have come out from an academic institution or a community partner organization. I just haven't recently seen it.

Q. Do you have any reason to believe that methamphetamine use or abuse is a growing concern?

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A. I -- yes. I did hear that. But lately the conversation has been more about fentanyl. But over the course of maybe {sic} last three years or so, methamphetamines were a topic of discussion.

But, again, I was very focused on COVID. So it was like, yeah, I hear you, but y'all work on it. Let me figure out the COVID issues. So my life was consumed by COVID even though there were other issues at play that staff are working on. I was just like, yeah, you guys do your thing and let me -- let me let me worry about this immediate fire that's consumed all of us, you know.

Q. Do you believe prescription opioid use is a growing concern in Tarrant County?

A. So I don't have recent data, but I know that somewhere -- and, again, memory fades me. I'll give you a broad time frame. 2016 through '19. And the reason I say that is there's different times, we've tried to write for grants and look at data from different angles. Somewhere in that time frame, I do remember a report that detailed, and I think it came from -- I forget the data set. It's the state pharmacy data set, PDMP something-something. I can't remember.

And we had looked at state trend versus Tarrant County trend. And it was a sudden acceleration

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from 2016 to '19 on prescription -- prescriptions being written for opioids where it was very strikingly strong increase in prescriptions being written for opioids.

And at some point, I think, later, the trend was starting to decline. But I just, kind of, remember a graph out of a report, and it was very striking at the time. And I don't even remember the exact time frame, but I believe the report was somewhere around the 2019 time frame when we were looking at that CDC grant submission.

And around the same time that, I think, I mentioned to you we were talking to Medstar, the ambulance company. And from there, we learned about the state pharmacy database, and I think we got access to it somehow and built that report to include in our justification for the grant.

But that's all I recall on that topic. But it was very a striking, sudden sharp increase in opioid prescriptions all across Tarrant County.

Q. So I believe you're saying that you recall at some point, prescription opioid use being a growing concern, but not presently?

A. The reason is I don't have present data.

Last three years have been a COVID-related blur. I mean, that's the honest truth.

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So even though the department has probably -- you know, my staff has been working on reports and data and putting up stuff, it's not like always registering in my head because I've been so busy with the major topic of the century which is COVID right now.

Now, we're starting to kind of ease into other things. So we're focusing back on our Community Health Needs Assessment. You know, looking at what topics are coming out of there. We're doing strategic planning on, you know, how we're going to, kind of, move the department forward and the Community Health Improvement Plan will be built. So things are starting to get back to normal where more attention will be given to these topics.

But last three years, I can't accurately tell you that I've looked at more recent data. But before that, the picture is very clear in my head because I saw that, and that was kind of a, wow, stop and look at this because this was, you know, quite striking. And then after that, everything's been a blur because of COVID because it's long days and COVID only.

Q. If there was similarly striking data in the past three years, do you believe your direct reports would have brought that to your attention?

A. Probably yes.

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But they were -- very honest, they were all very sucked into COVID also. So even if there were other things on their radar, sometimes they just didn't have the time to get the conversation happening about these other things. I mean, that's -- nobody will understand other than Public Health people. It might sound like superfluous, but we lived and breathed 24/7 and more if there was more, and there was no room for anything else. There really was not.

Q. Is it fair to say you don't have sufficient information to determine that there is presently an opioid crisis or epidemic in Tarrant County?

A. I don't have accurate data to talk to you about today. I mean, I can go ask the staff or you are welcome to go ask the staff, and I'm sure we'll pull up what's current and available to us.

I don't know that the trajectory that we were on -- I don't know that anything's changed. I mean, something's changed. That's good news. But the trajectory was like this, very sharply upwards on prescription opioids use.

And then later, again, some of the stuff that I'm telling you is anecdotal. That graph I remember in the data, and then other things that I heard.

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Methamphetamine use was there because we're the county, and there's unincorporated areas in the county. And I kept hearing, oh, there's, you know, meth use over there and this and that. And, you know, I heard from physicians, yeah, that's on the increase, okay. We're observing that.

And then lately, all of the conversation has shifted in local and national public health circles to fentanyl. So I'm not sure if that means prescription opioids are on the decline. If they are, that's great. But I don't have data to accurately say that that's the case.

Q. The term "crisis" and the term "epidemic" indicates a serious issue, fair?

A. Yes.

Q. Do you believe COVID was a crisis and -- or an epidemic?

A. Yes.

Q. And that was the focus of your attention for {sic} couple of years? That fair?

A. Yeah, since 2020. So we're going on about three years almost.

Q. And still is?

A. It still is, yeah.

I mean, it still takes up a lot of my time

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to deal with issues related to COVID. Even internal like department operations, right? A lot of HR and financing issues as COVID funding is declining, and we're having to terminate staff positions and all of that. And there was a lot of rapid hiring. And, now, that the dust has settled, hey, these are not the most productive people sometimes. So finding ways to, kind of, lighten that load. So a lot of that, you know, what we call the back-end fallout of COVID is still, you know, keeping us busy.

And then we had monkeypox in the middle and, you know, many other things. So there we go. Life is busy.

Q. (BY MR. CARDI) Okay.

All right. Let's -- you have a binder --

A. Yes, sir.

Q. -- nearby?

A. Uh-huh.

Q. You can go ahead and open that up.

A. Yes.

Q. Have you opened the binder, Doctor?

A. Yes, sir, I have. I'm on Exhibit 1.

Q. Okay.

If you would turn to Tab 2, please?

A. Okay.

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MR. CARDI: Greg, you can publish Tab 2 and mark it as Exhibit 1.

MR HOLDERMANN: (Witness complies.)

(Exhibit 1 marked.)

Q. (BY MR. CARDI) Do you have any recollection of this email from February 21st, 2018?

A. Recollection? No. But I'm reading it now, and, obviously, we -- we've had this conversation.

So --

Q. The subject line is --

A. -- I think this is -- this is --

Q. Go ahead.

A. -- what lead to that data deal that I was telling you about from the pharmacy board. So this is for the starting point of that discussion.

Q. Starting point of what discussion?

A. The -- the data that I mentioned that we received from the pharmacy board that eventually led to me -- or my staff presenting me that graph. You know, I might not have necessarily read this particular email because it was Tal Holmes, my associate director, and from our chief epidemiologist, and a couple of folks. Myself was copied, cc'd.

But do I recall. There was a meeting, I believe. And I believe it was at the Medstar office,

and they talked about the -- the drug prescription drug monitoring program. And then we requested the data from the pharmacy board. And then later, I believe, we got the data, and then my team was able to pull out that graph after analyzing the data that prescription drug use was on a meteoric rise in Tarrant County.

Q. So there's -- Denton is mentioned there in the first sentence and an opioid overdose project.

Do you have any recollection of what that was?

A. I don't. But Denton is a neighboring county, just north of Tarrant County. So they're a little bit smaller. We're about 2 million people. They're about a million people. Dallas County is to our east. So, you know, we kind of form the metroplex area counties, if you will. So there's a big metro area.

Q. But you don't have any specifics about Denton's opioid overdose project?

A. I don't.

Q. The --

A. I'm sure I've probably heard of it before. I just don't recall the details because it's been a while.

Q. Do you recall whether Tarrant County had a similar opioid overdose project in this time frame?

A. No, we didn't.

I believe what we were trying to do, from looking at this email, is gather our data sources and things that I've mentioned to you. That NSSP Syndromic Surveillance platform, we can look at chief complaint data and discharge diagnoses. So then we can build a query for opioids overdoses using some CDC analytics algorithms, if you will.

Then we were also talking about getting prescription data from the drug monitoring program at the pharmacy board.

And then medical examiner data I've talked about a few times, that those were some of the data sources that we would then use to create a grant application. If we get the money, then we would then go further into programming.

Q. So it was Denton at this time also seeking to apply for this same grant?

A. I don't know.

Just my guess would be that they probably were not qualified at the time. Because if our numbers were small for CDC, Denton's were probably smaller, but that's just a guess.

Q. And it appears to me -- and correct me -- or if you disagree, let me know -- there's a discussion with Denton about the various data sources that each county

has access to and trying to achieve comparable results or at least --

A. Well --

Q. -- methods to measure --

A. Yeah.

Q. -- opioids overdose within your counties; is that fair?

A. Correct.

And the other piece is that Tarrant County sort of is the host entity for NSSP, and we serve a 49-county region through the NSSP platform. So if Denton needs access to ER data for opioids overdoses, my team would have to build the query, filtered by Denton County. So they can see their. We can see our data.

So Bill Stevens, or William Stevens, was infomatics manager at the time, and that's why I think he was being included on the conversation. So that his people, who are the techie people, can build that query if need be.

Q. But it looks like there was a request or discussion of a request for prescription data from a Texas prescription drug monitoring program; is that fair?

A. That's correct.

I think that's the data we received later

and less through the generation of that graph that I talked about that showed a very sharp increase from like 2006 to 2019 time frame in Tarrant County related to opioid preparations being used and being prescribed in Tarrant County. It was a very striking graph.

If you give access to all these reports, probably have it somewhere.

Q. Tarrant County does not have continuous access to prescription job monitoring data? It has to make a specific request?

A. That is correct. I don't believe we have continuous access to that data set.

Q. Today you don't, just like in 2018?

A. I don't believe so, no. Because if there was, I probably would have received a more updated report. And I think -- now, that I connect the dots, that's probably the reason why all my team got busy with COVID and did not request another update because usually getting data from the state is a long, drawn-out process. So they may not have had the time bandwidth, if you will, to get another updated data set.

Q. There's also a discussion here of the medical examiner pulling death from opioid information out of their data.

So there's not a process in place for the

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medical examiner to continually supply data to Public Health Department?

A. I -- it's kind of a mixed bag. General answer is no because we don't have direct access to their database where we can get continuous accessed information.

What they do is they post a lot of death reports and summary related to that and causes on their website. And that's where Micky Moerbe, our biostatistician, draws most of her data from. And that's our first source of information.

And if there is anything specific that we need to get details from, there are county departments that we reach out, and they run a specific query for us. And we then get the updated information.

So is there a mechanism? Yes. But is it like automated live, realtime where, you know, we can go in any time? No, it's not. I mean, it's sort of by-request basis or whatever is publicly available.

Q. All right.

If you can turn to Tab 3?

MR. CARDI: And, Greg, if you can publish Tab 3 and mark it as Exhibit 2.

MR HOLDERMANN: (Complies.)

(Exhibit 2 marked.)

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Q. (BY MR. CARDI) Do you recall this email, Doctor?

A. Yeah, I believe so.

Q. What is the Tarrant County opioid report?

A. That, I don't specifically recall, but could be one of the data briefs that we did back then.

Because I -- my team, Micky Moerbe and her team, does put out data briefs from different topics that they find in this assessment data, if you will. And they try like almost every month or every couple of months to go to a different topic, pull out the data, make a meaningful report.

So that whoever needs it -- a lot of university partners need it, academic institutions or even community organizations, they want to look at because they have programming going on, or they're applying for grants, and they need county-level data. So they look at those reports. It could be referring to that.

Or it could be something that we pulled from the Syndromic Surveillance System to create a specific report for something. But I don't exactly recall what this specific one is. It's one of those two, I think.

Q. This email chain from April of 2018, subject is "Emergency Departments Opioid Case Data" seems to be a discussion following a request -- a FOIA request for information on -- on opioid cases; is that fair?

A. As I recall, yeah.

Q. Do you have the second page there?

A. Yeah, I do. That's right.

I believe DSHS received a FOIA request related to pulling out opioid-related data from the Syndromic Surveillance platform because they have the same platform also, and their PIO was sending heads up to different programs that had access to that data set that you may also receive a FOIA request. And they just wanted to make sure that we do not release patient-level data because that would be a HIPAA violation.

So that's, kind of, the gist of the conversation. Hey, heads up. Make sure you don't release. Because the request was very detailed. Don't release data elements that may make you violate HIPAA.

Q. Who is William Stevens?

A. He is retired now, but he was our infomatics manager. I think he retired, like, late 2018.

And somewhere after that, Rasneet Kumar -- and I don't know if you she was -- she's in your email or whatever -- but she's been the infomatics manager ever since.

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Q. William Stevens follows up with a Talmadge Holmes, middle of the first page here, and says (as read): "The cat is out of the bag now about our NSSP participation."

What is -- is he referring to there, if you know?

A. So -- so the request came from a reporter, I believe, that reached out to DSHS because they found out that DSHS has a Syndromic Surveillance platform where they can run a query and look at statewide opioid-related visits like the email states; that they can look at chief complaints and final diagnoses before the patient is either admitted or discharged from the ER. And they were reaching out to the state that we need access to all these details because opioids was a hot topic around the time and a lot of national coverage and all that.

Somewhere in that conversation, I guess, somehow they found out that Tarrant County maintains access to 49 counties in North Texas. And that's what the heads up was from Carrie Bradford at the state that, hey, you might also get a follow-up data request, and they also sent a heads up to Houston because they maintained another subset of the southeastern portion of the state.

So they were -- kind of a long history. We were sort of the frontrunners of this system. They didn't have it. Then Houston joined. But we covered North Texas. They covered Southeast Texas. There was a big gap.

Eventually, the State of Texas joined in, and they were trying to take it over as a whole. We're like, no, we've been working on it for many years. So they kind covered the rest of the state, and we were sort of data sharing to create a composite state picture.

So they were giving a heads up that y'all may get similar data requests. So that's what he means "cats out of the bag" that we also have access to this system. So a follow-up media whatever may come our way also.

Q. And William Stevens also notes that some level of concern about the ability to provide reports because there's "so few opioid-related cases."

A. Yes.

Q. Yeah.

A. So at the time without really, like, fine tuning the data, the big concern always remains. And, again, if you're familiar with HIPAA law, we're supposed to not release a lot of information. And if the numbers

are few, it is easy to sort of identify a person. So the general rule of thumb without looking at the data is that, hey, if there's not a whole a lot of data, then don't even talk about it because it's going to potentially get down a path where we're really -- and they say we're going to have to talk to the DA's office and make sure we don't release anything that violates HIPAA.

Q. Do --

(Simultaneous cross-talk ensues.)

Q. (BY MR. CARDI) Today, do you recall then the numbers of opioid-related overdoses as of April 2018 roughly?

A. Yeah, and I don't.

And I would sort of -- you know, here I'll make an opinion that he was making an -- sort of an educated guess just looking at the system, but the query I don't think was set up at that time. They were talking about setting the query up. So just looking into the system, he was probably not seeing a lot of data flow.

And the media FOIA request was going to be media, like, hey, what do you have? And his concern was, like, we can't share this because it's going to be potentially identifiable.

Q. Because he didn't have that many cases in the data sources to report, correct?

A. Correct. Correct.

And it's because, again, the query was not set up. But once you set up the query, you probably find more data. This is just what flows into the system on its own without actually asking the system to find, hey, what is the chief complaint that relates to opioids? What is the final diagnosis that relates to opioids? Run an accurate analysis.

Q. Why do you believe a query had not been set up yet?

A. Because I believe that got set up -- because this is a time when CDC was giving the algorithm or talking about sharing the algorithm. I believe we actually set up the query once we got the money from New York City, and that happened '20.

So, again, my time lines are a little rusty, but I believe that's the time we set up the query accurately and started getting some more information. But then information was there, but we had turned our attention to COVID. So a lot happened.

Q. And when was that again, the money received from New York?

A. Late 2019, early 2020. Something like that.

Q. And when do you recall seeing this drastic spike in cases?

A. Okay.

So that's a different data set, not from this query. That's the pharmacy board data set. And I believe they had requested it somewhere in 2018.

If I am accurately recalling, which I'm not 100 percent certain, somewhere in preparation for this grant opportunity, we had -- and, again, a lot of times these things are alerted several months ahead, like, hey, CDC is working on this big package and be ready and get your data ready and get your coalition if you need to be participating in who's going to do the work and all that. So somewhere along the way from this point onto like the time we submitted the grant in maybe 2019, I did see that report because the pharmacy board data arrived, and that report was derived out of the pharmacy board data. I'm sure there's other components in there, but that graph that I keep talking about was derived from the pharmacy board data.

Q. Doctor, can you flip to Tab 4, please?

MR. CARDI: And, Greg, if you would mark Tab 4 as Exhibit 3. I'm going to screw up this numbering at some point. I'm confident.

MR. HOLDERMAN: (Complies.)

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(Exhibit 3 marked.)
A. Yep.
Q. (BY MR. CARDI) Is this the CDC grant that you were speaking of earlier?
A. Yes.
Q. Okay.
And this email -- the latest in the email string, February 11, 2019, subject line: "Opioid Overdose Funding Opportunities." Talmadge states that (as read): "We're not eligible since we didn't register at least 395 drug overdose deaths 2017"; is that correct?
A. That is correct, yes.
Q. And -- and what data would this number be generated from?
A. I don't recall, but two data sources do come to mind. Primarily it would be the CDC Wonder because that's our composite data set. We may have added local data from, like, DSHS because they have state-level data or some data from medical examiner because not every one of those overdose deaths becomes a medical examiner case. So their data is also not complete. But I'm not pretty sure the primary data source was CDC Wonder.
Q. When you're talking about not having established a query yet as of April 2018, in relation to

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the last exhibit, this query was in what system of data?
A. So it was in the NSSP platform, and it's not related to what you're talking about now. These are drug overdose deaths. NSSP platform looks at chief complaint coming into the ER and discharge diagnosis, whether the person is being admitted to the hospital or discharged to home care. So at that point, the person is usually alive; but, you know, the death data comes from other data sources after a long time.
Q. But an -- an overdose being the cause of someone's admission would be within NSSP, correct?
A. Correct. Yes.
Q. All right.
And CDC Wonder -- would the board of pharmacy data be included in the CDC Wonder system?
A. I don't know. I don't believe so. Yeah, I really don't think it does, but I'm not 100 percent certain.
Q. If we go to Tab 5, Doctor.
MR. CARDI: Greg, this is going to be marked as Exhibit 4.
(Exhibit 4 marked.)
MR. HOLDERMAN: (Complies.)
Q. (BY MR. CARDI) Doctor, do you recall what is now marked as Exhibit 4, an email dated April 30, 2019,

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subject line: "Data Regarding Opioid"?
A. Yes, I do. You know, now, that I'm reading this, yes, this is coming back because this was all that discussion we were having around the time.
And go ahead and ask your question because I have a point that I want to kind of clarify also.
Q. Go ahead.
A. Well, I was going to say this exactly shows you the challenges we have, right? So even the biostatistician is saying that medical examiner data is not a complete, accurate representation of what's happening for many reasons. One, you know, a lot of times they report data regardless of the county of residence, and that's all we have until we ask for a specific query, right? So this post on the website, hey, so-and-so person died, and here's the cause of death and usually it's for the next of kin and so forth.
But we preview that website and query that data on our own without bothering them unless specifically is needed. But also not every overdose death is recorded with the medical examiner because not every one of them qualifies. Sometimes they're just dead in the ER, died in the hospital, and doctor made a ruling; and that's fine enough. They don't need to be a medical examiner case unless there are suspicious

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circumstances around the death.
So that just kind of shows you the challenges and goes back to why we need funding in Public Health to do accurate surveillance of where the real problems are, to cover the data gaps, and fully understand the deep impact of those deaths in our community. Because there's changes everywhere.
You can see the struggle trying to piece together different data pieces to show a composite picture to the CDC. Hey, we have a need in our community.
Q. Does any department presently within Tarrant County have that ability to piece together the data sources and provide an accurate reflection of opioid abuse cases in Tarrant County?
A. I don't know for sure, but I mean it would probably fall on the health department. That's just how usually things go.
If we were given the funding and the marching orders to go put this together, I think our team can. It's just that we've never had the resources to do it. That's been the challenge, and we've tried a few times to get the resources.
Q. Does MHMR aggregate that data?
A. I don't know. I'm sure they do to certain

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level {sic} because I'm sure my teams worked with them.
And in this email, you'll see that they're trying to get some data from us because they're very focused on getting people into addiction treatment and dealing with that immediate health crisis versus big picture because, again, that falls on health departments usually.
Q. Do you believe that if you wanted to right now you could get an accurate number of opioid-related overdoses in Tarrant County and, let's say, for 2022?
A. No. I could get you somewhere close, but it's not going to be 100 percent accurate.
I mean, it would be representative of what is happening in Tarrant County. And the limitations related to that are disparate data sources. No one entity particularly funded to collate and create a composite picture.
And that's the gap that the health department's been trying to address, trying really hard to get funding to do that because of the challenge that we see. We see a growing need. We see trends. We're in a very unfortunate spot where we can't get the intention and the resources to actually pull it all together. The glue concept that I explained earlier, we see our need to do that.

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Q. So let's -- let's speak of opioid-related deaths. Those would -- the data on opioid-related deaths could be obtained from medical examiner, and then it could be obtained from hospitals and cases that are not otherwise reported to medical examiner.
A. Yes.
Q. If you have those two sources, would that get you pretty close?
A. That would get you pretty close.
And then I know that DSHS does -- because they have -- they're the state. They have more authority on reporting requirements, and they're a very large entity. Like we're very focused on public health. State has Health and Human Services Commission that has regulatory authority on hospitals and nursing homes and many other entities.
And part of that is DSHS. So they have a regulatory arm that deals with hospitals. So they can force a lot of data that comes to them. They can force laboratories to share a lot of data to come to them. They can require HMRs to report a lot of data. We don't have any requirement authority, if you will.
So -- and getting data back in a composite way from the state is also a challenge. They're just kind of big and data sources come at different --

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different angles. They have pharmacy board data.
So the concept is that can we get this done? Yes. But it's going to take a very methodical, thought-out approach with funding and resources to pull it all together. In absence of that, just like you said, a good -- it gives you a good idea of what's happening in the community looking at that data from the medical examiner and from the hospital.
Q. Does DSHS have hospital and ME data in Tarrant County?
A. I don't know.
But can they get it? Absolutely, they can. I just don't know that they do.
Somewhere in this email chain, you'll find a very frustrating email that at the time DSHS declined to participate in the grant application because they didn't feel they had the resources, and the priorities were different at the time for them. So it is what it is.
Q. Can you agree that DSHS is best situated to be the entity that aggregates this data since they have the power to obtain it from hospitals?
A. Yeah.
I mean, it's kind of a long, drawn-out answer there. But the short is, if they -- same like

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us. If they have the funding and the priorities set for them, they can do it because they are a state entity, and that gives them a lot more authority to work on that. And if they get into any issues, they can work with legislative folks at the state to create law that's smooth out the way.
For example, COVID happened, and they were not getting laboratory data. Only what is required is positive case reporting, and people wanted to look at the whole picture -- how many positives, how many negatives. They talked to the governor. The governor issued an executive order, made all the laboratories report to the state all the tests -- positive, negative, otherwise, repeat tests, everything.
So can it be done? Yes. Does it need a lot of moving parts? Absolutely.
Q. So it sounds like DSHS has the authority but maybe not the funding?
A. Yeah.
Q. Isn't it accurate that Tarrant County, even if they had all the funding in the world, would not have the authority?
A. Yeah, we wouldn't have necessarily the authority. But at the local level, a lot of times, that's what health departments are known for. We are

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very collaborative and usually are successful in bringing a lot of partners to the table.

And that's -- from just experience in public health, we do serve as that glue. That's what health departments do almost everywhere. We tend to get people to the table. Here's the issue. Here's what we can provide in terms of data or here's the gaps. Everybody give us your data. We'll bring you back a composite report, and then let's all look at it all together. Where is the problem in our community? What do we need to do to resolve it? Most of the time we're fairly successful.

Q. Hospitals provide that data and say opioid-related deaths to Tarrant County Public Health?

A. Currently, they don't.

And the reason is, they have a little crutch, right? So it's not required. But then they're like, if you really need to go look at our ER data, you've got access to Syndromic Surveillance. Go take a look in there.

But if we were to get funding, get everybody on board saying we're doing an opioid overdose project -- like you've heard the term within county and all that -- I'm sure there will be, you know, participation. Is it going to be 100 percent by every

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hospital system? I don't know until we try that out. But, generally, we bet good participation.

Q. I don't do this work obviously. I'm just having some trouble understanding what the funding is needed for. If hospitals frequently participate with Public Health initiatives, isn't it simply a matter of Public Health asking hospitals to provide data?

A. Yeah, it's not that simple.

Everybody is resource constrained. So when funding is there, usually that comes with letters of support and commitment towards the project. Who are going to be your participating partners?

A lot of times, you know, we'll hire staff, and we'll give them probably some recipient moneys to dedicate some staff time towards pulling some specific reports or creating connections between data systems. It goes through legal review of data sharing.

All those -- so a lot of time and effort and spent, and that's what the moneys are for to cover those costs. It's to pave the way for those things. In an ideal world, yeah, all of this should be interflowing with each other. You know, everybody working together. That's now how it works in real life unfortunately.

Q. I mean, to your knowledge, do most hospitals keep and aggregate this data? I mean, I would think --

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and I'm just a layperson -- that hospitals have a system that says we've had this many overdose -- opioid overdoses this year?

A. I don't know.

I would presume they do. I mean, they have EMR systems, which electronic medical records; and that's the reason why a lot of push went on for Public Health to electronic surveillance and hospitals to go electronic so that these reports could be run on a timely basis, but requirements for sharing were kind of weak.

Q. Right.

And that's why I'm circling back to the authority. That's a component that Tarrant County wouldn't have, only DSHS even if Tarrant County did have the funding?

A. Yeah.

Q. Okay.

MR. CARDI: What are we on here? Tab 5? I believe Exhibit 4?

MS. AYACHI: Yes.

Q. (BY MR. CARDI) Doctor, if you would move to Tab 10.

A. Okay.

Q. Please.

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MR. CARDI: Greg, if you would publish Tab 10, and mark it as Exhibit 5.

MR. HOLDERMAN: (Complies.)

(Exhibit 5 marked.)

Q. (BY MR. CARDI) Doctor, this appears to be a letter to the National Center for Injury Prevention and Control written by yourself and Glen Whitley; is that accurate?

A. Correct.

Q. Do you know what this letter concerns?

A. Yes.

So this is the letter of intent to apply for that grant that I was talking about earlier that we applied to the CDC. It appears that we were identified as eligible communities. And later when we submitted our application. And you saw some of those email frustrations there saying, we're not qualified because we didn't hit a certain number of deaths in 2017 while the grant is in 2019, right? So this is the grant that we had applied for and did not succeed. And, now, we've applied for {sic} again and waiting to hear back.

Q. The last sentence of the description paragraph states (as read): "The opioid overdose problem will require solutions that combine sensible prescribing, addressing social determinants of health,

decriminalizing evidence-based interventions including medications and treatments, and treatment of comorbidity."

Did I read that correctly?

A. Yes.

Q. So which of those efforts would Tarrant County have played a direct role in?

A. So multiple of those.

But, again, we wouldn't be doing this alone. As you saw, there were participating organizations at the time that identified Challenge of Tarrant County, which I completely forgot mention to at all. It's a nonprofit that deals with substance abuse-related issues.

The sheriff's department because they were actively involved in, like, Narcan, you know, carrying Narcan in their medical, like, kit, if you will. So they were kind of showing leadership in that area.

MHMR of Tarrant County obviously. The JPS Health Network is the county-funded hospital system that I mentioned. The health district, if you will, hospital district.

And they end up with a lot of people showing up in their ER. Because a lot of times, they're a public charge. They don't have insurance. They've

got drug overdose happening, and it ends up in the JPS ER.

So those are the participating organizations.

But I could certainly see, to answer your question, Public Health, working with many partners on educating the providers about sensible prescribing because we had generated that report out of the state pharmacy board data. I don't think anybody had known or seen that -- that it was such a striking increase of opioid prescriptions in Tarrant County.

To show that visually to medical prescribers and pain clinics and others would be a talking point that we need to be judicious about this because people can get hooked on -- and we would bring other entities that have firsthand knowledge on how that is working and impacting the community.

Then we would also -- working on social determinants, I mean, that's what the health departments do anyways, but it brings a lot of different sectors in to fix like issues that impact health. Whether somebody doesn't have a good job or doesn't have health insurance or hasn't completed their education or lives in a crime-ridden zone, and that's why they don't go out or exercise or take care of their health. I mean, a lot of

those issues intertwine and impact one's ability to achieve health. I mean, it's a big topic, but it's one of those things that almost everybody agrees that it leads to bad health outcomes, and we all need to be working methodically to resolve those issues.

We would pull in the sheriff's office, probably our DA's office probably, and many other community entities looking at, you know, decriminalization of things that can be like create community diversion programs, things like that. And some of that stuff, I think, is already set up in all those.

And other evidence-based interventions, for example, like Narcan and a few other things. And that would be working with different medical groups, pharmacy groups, and all those type of things to reduce deaths.

And then treatment of comorbidities. I mean, that's generally mental health issues, other health issues that may lead to poor health outcomes. Let's say you have heart disease, and you have diabetes and blood pressure, and now you're also addicted to medication. You're likely to have the worse outcome than somebody young and healthy who's addicted because that's the one issue they're dealing with versus five health issues. So getting people to take care of their

health in general is always a good strategy in prevention.

So we would be involved in every one of those to different levels, not the lead on everything, but in -- in certain components.

Q. Education and collaboration data gathering, that's the role that you would have envisioned? I mean, that's a vast simplification potentially; but is that fair?

A. Yes, that is fair. I mean, that's what I mentioned to you earlier too.

Q. Sure.

A. If you boiled it down, we would gather better data to show a composite picture of what's happening in the community. Then thing bring everybody together. Here's what we think will work. What do you think will work? And then we kind of resolve that together.

Because not everything's under our purview. You know, law enforcement's not under our purview, but we can talk to them. Say, hey, not everybody needs to be thrown in jail. Let's figure out a way how to better manage this. You know, do we get them into -- right into an addiction treatment center instead of throwing them in jail first? I mean, you know, that kind of stuff.

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Q. Okay.
Can you turn to Tab 14, please?
MR. CARDI: Greg, we can mark this as Exhibit 6.
A. Sure.
MR. CARDI: Correct?
MR. HOLDERMAN: (Complies.)
(Exhibit 6 marked.)
MS. AYACHI: Sorry to interrupt you, Michael. Just asking if the prior exhibit and this exhibits that you're marking now, if they have parent emails that were attached to them?
MR. CARDI: I believe that they all did and are present in the exhibits, I believe.
MS. AYACHI: Okay.
Just to the extent that they do not include the parent email, I'm not going to instruct the witness not to answer, but I just want to make that noted on the -- on the record, okay?
MR. CARDI: That's fine. And we can even supplement them if we find that to be the case after we close out the deposition.
MS. AYACHI: That sounds good.
MR. CARDI: I have no reason to think that they're not included, but certainly we can.

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Q. (BY MR. CARDI) Doctor, looking at Exhibit 6, what is this document?
A. So, I believe, this is usually -- and, again, because the context is missing, usually these talking points accompany data briefs that my team -- Micky Moerbe's team may be putting out on our website. So when we put out data briefs, a lot of times we get out-of-the-blue media calls, and, you know, I've approved though data briefs like, let's say, a month ago and we went through the approval process, got posted. And out of the blue, the PIO's getting a call. Hey, Vinny, they want a comment on this issue. I'm like, hey, what are we talking about because it's been a month or more?
So they usually have these talking points. So we pull it out into the email saying, hey, sure. Let's review what we put out in the data brief. What are some anticipated questions and what are the talking points that we may have to talk to the media about?
Q. Do you know what data would have established these numbers set forth in the data brief talking points we're looking at?
A. I don't know. That's the honest answer.
Q. Is this the data from -- I guess, to paint in a paragraph, it says in 13 to 17 and also references a

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figure from 2008 to 2017, Paragraph 2; is that accurate?
A. Yeah, looking at the paragraph there, yes, that's what it says.
Q. It says under Paragraph 1 that (as read): "Tarrant County had the lowest overdose mortality rate and is significantly lower in the" -- "in U.S. and Bexar, Dallas, and Travis Counties."
Has that always been the case? Do you have any knowledge?
A. I don't.
Yeah, this is data that Micky and team probably pulled out from one -- CDC Wonder or some of the other systems that we use and compared it to other large counties in Texas.
Q. If you go to Paragraph 3, it discusses the -- it discusses overdose death, and it places unspecified drugs as 40 percent.
Am I reading that correctly?
A. Yes.
Q. Heroin is 23 percent; psychostimulant with abuse potential as 20 percent; 15 percent, other opioids; natural and semisynthetic; and then 14 percent, cocaine?
A. Correct.
Q. Do you know if those -- if that breakdown

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remains somewhat similar after 2017?
A. I don't.
I would have to have Micky run a similar comparative report for recent data.
Q. You spoke of -- of heroin and fentanyl being a growing concern presently.
And at least according to this data, heroin was top five drug overdose deaths from '13 to '17.
So is it -- is it continuing to increase?
A. So just to be correct, I didn't mention heroin because I didn't have the data handy. I did say that anecdotally I'm hearing more about fentanyl now in Tarrant County and public health circles and the state and nationally. So that's where I was deriving my understanding from. You asked me about heroin, and I was like I don't have any public data that I can recall.
Q. Yeah.
A. I'm sure it's an issue. I didn't -- I didn't have any opinion on heroin.
So, fentanyl, yes. I think that's the current darling topic unfortunately, so...
Q. I appreciate that clarification. I recalled my initial question being "is there a heroin crisis or epidemic in Tarrant County?" and I thought you said, "Well, I don't really have the data, but I do believe

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it's a growing concern." And you said the same thing with fentanyl.
Am I wrong about either one of those points? I think we're saying the same thing.
A. I think we're saying the same thing.
Q. Okay. Just confirming.
A. Yeah.
Q. If you would turn to Tab 16.
MR. CARDI: And, Greg, if you would mark it as says Exhibit 7.
A. That's the graph.
MR. HOLDERMAN: (Complies.)
(Exhibit 7 marked.)
Q. (BY MR. CARDI) So what are we looking at here on the first page --
(Simultaneous cross-talk ensues.)
A. -- this one --
Q. (BY MR. CARDI) -- of Exhibit 6?
A. I know. So this one -- the first one is an opioid-related deaths among Tarrant County residents from 2000 to 2016. And so that one that -- that's the whole report that I think I was mentioning to you. And somewhere down the road, there's graphs that I mentioned from the pharmacy data that shows increases in prescription drug use.

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But this one talks about opioid deaths. And I think as we dived or looked into the data in a little bit more in detail, Austin -- now, that I'm looking at it, comes to mind that had a pretty huge increase in overdose deaths, and that was driving Texas rate pretty high, while Tarrant County was somewhat doing okay. It wasn't like, you know, flat, but it was trending gently upwards, an ebb and flow every year.
Q. So Figure 1 is opioid-related deaths among Tarrant County residents, and it -- it is the solid line that's mainly staying below five deaths per hundred thousand.
Am I reading that correctly?
A. That is correct, yes.
Q. So, generally, following the Texas rates, which is the dotted line?
A. Yes.
Q. More of a zigzag pattern?
A. Yes.
Q. And opioid, for purposes of this figure, includes opioid -- opium, heroin, other opioids, methadone, other synthetic narcotics, and other nonspecified narcotics listed as the contributing cause of death; is that correct?
A. Yes.

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Q. Okay.
So National Center --
A. 45 --
Q. Yes. Sorry. Go ahead.
A. 45 percent of overdose deaths in Tarrant County involved an opioid.
Q. 45 percent? Where are you looking now?
A. That second bullet point --
Q. Go down --
A. -- in 2016 --
Q. Okay.
A. -- 45 percent of drug overdoses deaths in Tarrant County involved in opioid.
Q. And that would be likely an opioid including opium, heroin, methadone, other synthetic, all of those, correct?
A. That's safe to assume, yes.
Q. The Natural Center for Health Statistics, is that of the data sources a more full and reliable data source?
A. Yes.
It's part of the CDC, and that's where I think the CDC Wonder platform resides because they -- CDC is made up of multiple health centers, and this is -- like in the health department here, I have the

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infomatics division. Just like I was trying to work and create a health data warehouse in Milwaukee. Same concept. There at the national level, they have an entire center dedicated to collating the entire nation's data and put out health information in various reports. But that's what they're -- they're experts on health data.
Q. The mortality rate for opioid-related deaths in Tarrant County was 4.8 deaths per 100,000 in 2016. There were 97 of them in Tarrant County in 2016.
Am I reading that correctly?
A. Correct.
The qualifier that's what we knew at the time because not everything is easily accessible, but that's what we were able to gather.
Q. You don't know what data was omitted or what data sources were omitted from National Center of Health Statistics at this time, do you?
A. I don't, but that's certified data. So fair to assume that that is -- that is what the national and state entities all will agree that that's what the future was.
Because that data is multiple layers of approval through local, state, federal authorities before it's certified. And usually that's why they're a

little behind. On -- I think this one is created in like 2019, and we have data only until 2016 because they go through several levels of accuracy checks and certifications; and that is official data.

Q. Figure 2 deals with opioid deaths among Tarrant County residents reported by the medical examiner's office per month.

Is that -- am I reading that correctly?

A. Yes.

Q. And from 2015 to 2018, it looks like an increase. I wouldn't say a drastic increase.

Would you agree?

A. '15 to -- you're looking at the Figure 2?

Q. Yes.

A. And you're saying from what year to what year?

Q. 2015, it's 72; and then 86 in '16; and then 92 in 2017; and, I guess, 11 at the beginning of 2018.

Am I reading that correctly?

A. Yes.

But raw numbers, I wouldn't venture to guess whether that is significant or not because that's where the biostatistician comes in and does all our analysis if it's significant or not in terms of statistical significance.

Q. Sure. And I'm not trying to say any number is

significant or insignificant. I'm more speaking of this drastic spike that you were speaking of earlier.

This is not it?

A. No, this was not it, no.

Q. Okay.

MS. AYACHI: Michael, I'm sorry to interrupt you. For this document, I see that there is a parent email that does provide some context. I don't know if you want to take a moment and, like, just pull it up and present it digitally, but it does provide context to the completion of some of these figures. So I would...

MR. CARDI: Parent email in which individuals discuss data?

MS. AYACHI: Yes.

MR. CARDI: If you'd like to -- to present that and go through it with Dr. Taneja, certainly able to. I don't see the need to. We're just talking about data here. That would be my thought on it.

MS. AYACHI: You're welcome to do what you want. So I'll take to the use of this without the parent email giving context. Just putting that on record.

MR. CARDI: I'm not really clear on the basis of the objection. This is data reported by

sources that we're discussing. I'm not sure how an email discussing data somehow affects the reliability of the data.

MS. AYACHI: I mean, I can tell you or ask him about it myself. But I'm looking at the parent email, and it shows that some of the numbers are not -- are pending. So that indicates to me that some of these may not be final numbers.

MR. CARDI: We can look at it on a break.

Do you have a number?

MS. AYACHI: Sure.

MR. CARDI: Bates number?

MS. AYACHI: Yeah, the Bates says TARRANT_00343779.

MR. CARDI: Okay.

Q. (BY MR. CARDI) We are on Figure 3, I believe, Doctor. "Percentage of Opioid Deaths Among Tarrant County Residents Reported by the ME's Office." This is just presenting that same data potentially? The demographics?

A. If I may, just a point of clarification?

Q. Yeah.

A. Because I mentioned to you on Graph 1 --

Q. Uh-huh.

A. -- what comes from National Center for Health

Statistics is certified accurate, final data. A lot of these other graphs in the report -- and you will notice that somewhere either in the report or in the emails, repeated comments that this provisional data may be subject to change as data finalizes.

Because at the local level, a lot of things change really fast. But by the time it goes through certification for most of the state to the CDC, it gets accurately represented. It's a couple {sic} three years before the data is considered final and stable.

So some of the other graphs are very fluctuating because it was pulled from raw data. Hey, what do we have today? Show us that, so we have some idea of the trend.

Q. And you're speaking of medical examiner data?

A. Well, medical examiner data and even some of our other data reports.

And, again, it varies by system. And, usually, they're very good about putting an asterisk where they believe the data is provisional. But some of this stuff is very fluctuating because it's pulled off of a website. And without, you know, going into exact details, maybe it's the medical examiner signing off on this, blah, blah, blah. All of that. So just be mindful.

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And then the -- the reason I kind of got hung up on the differences between the years, the numbers may look 72 versus 86 versus 92. You and me might look at it as no big deal, but when they do statistical analysis, it may be statistically significant from year to year based on population and other criteria.

But, again, that's beyond my understanding. I let the biostatistician tell me. She's the expert. And a lot of times in those emails, she'll note whether there is significantly statistical difference or not.

Q. Where does it say here that data is provisional and not final?

A. It may be in the email.

But a lot of times I know just from working with the biostatistician, they'll put an asterisk somewhere if the data is provisional.

But since this was an internal report, they may have gone through all that checks and balances. Because as you can understand, this is a confidential, internal report. So it was kind of a raw report to us saying, hey, here is what we have. Now, tell me what you need to package for the grant application, and then we'll make it look pretty -- actual do full analysis, color graphs, all the little provisions that they need

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to put on. Do it in the right way.

Q. Other than your counsel's testimony on this subject of the email, do you have any specific recollection of the time this report was generated it was based on provisional data?

MS. AYACHI: Objection, form.

A. Yeah.

Actually in some of the previous exhibits that we saw in emails and whatnot, I did notice those comments and asterisks. So --

Q. (BY MR. CARDI) Why aren't those comments here in this report?

A. I don't see them, but it may be in the email, you know.

But I know that we don't get certified data from the medical examiner because we're just off brought it up from their website. That's usually what we do.

Do we ever ask for an actual raw report from their system? Again, raw reports shared between departments are usually provisional.

In fact, on our website, a lot of times we'll put out data because people get real upset. Well, why are you holding this data when you know there is this happening in the community? Okay. Well, we'll put it out provisionally, but stuff happens.

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I mean, I'll tell you during COVID and in many things, we said, hey, there's a case of COVID here or a death of COVID here. Turns out, it wasn't even a Tarrant County resident once everything was all settled in. Then the people got mad. Oh, you lied to us. No, we didn't. It's provisional data. It takes a while to figure everything out, you know.

Q. So your recollection is that some of the data in Exhibit 6 here may have been provisional at the time, but not the National Center for Health Statistics data --

A. Yes.

Q. -- that's here?

A. Because that is finalized data.

That's why it's like three years behind. Frustration source for a lot of us, but that is deemed to be the nationally certified accurate data. They don't change after it's posted.

Q. What does Figure 5 show?

A. Figure 5, okay. So that was the graph, I think, I was talking about.

Prescription drug use. And if you want to look at -- and it's hard to see on a black and white, but it was a pretty sharp increase going --

Q. This is -- Figure 5 is Opioid Prescription

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Rates Per Hundred Persons, isn't it?

A. Yeah. That, I believe, yes.

And, again, I had my time frames wrong. This one is 2006 to '16. So there you go. Recollection error.

But, yeah, there was a pretty sharp increase in prescription, you know, dispensed per hundred residents. That was kind of following the national trend here in Tarrant County, and it's hard to see the black and white lines; but I believe this same thing happened in Tarrant County.

Q. One prescription is going down here between 2012 and 2016?

A. Yeah, I think that was the recollection error that I had. I thought the graph showed 2016 to '19, but it showed 2006 to '16. And then towards the end, it was tapering off.

Q. And so we're not talking about a drastic spike? We're talking about a drastic decrease in opioid prescription rates?

MS. AYACHI: Objection, form.

A. No.

Yeah, the later half, but you're missing the point. In 2016, it was almost a ten-year period. In 2006 through '12, you can see it was a sharp

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increase.
And, remember, the recollection I had about when I was in Detroit, Wayne County from '11 to 2014. A lot of buzz was happening in those circles. Hey, prescription drug use is on the increase, and it's causing issues in our communities and health departments need to be participating and all that. This gives you context on why that conversation was happening around that time because we were at the peak of that problem.
Q. (BY MR. CARDI) 2012?
A. Yes.
Q. Okay.
So isn't it true that it drops much more sharply between 2012 and '16 than it increases between 2006 to 2012?
A. I don't know about the slant, but it does appear that way on the graph. Yes, you are correct.
Q. Is there anything in this figure that indicates any problem with opioid prescription?
A. Yes.
MS. AYACHI: Objection, form.
A. The six-year increase trend that got us into trouble nationwide.
Q. (BY MR. CARDI) What in this data says that?
A. Sharp increase in opioid use. Like suddenly

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people decided they all have pain for six years. You tell me.
Q. Okay.
Well, we spoke of physicians earlier examining patients and determining legitimate medical purpose for a prescription.
So unless they didn't, I'm just not sure how this data standing by itself shows anything other than an increase in prescription rates.
Can you help me understand?
A. Yeah.
This one, again, is giving context to the conversation that there was -- exactly what the graph is. There was an increase in prescription rates from 2006 to '12. '12 appears to be the peak on the graph, and then there was a decline, right?
And I don't have any more data after 2016 to show is it continuing to decline? Has it leveled off? All of that.
But all of the conversation we had -- hey, when did you first hear that prescriptions were an issue? Told you in the 2011 to '14 time frame. Before that, was there conversation? Probably. But I was not high enough in the chain to be involved in a lot of those conversations. I was given my job. Do your job

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and you're done. As I became the deputy director and the acting director there, I got involved in a lot more conversations because I had to over and present the department, and it was around the peak time that you're seeing on the graph. So that gives you context to all of that conversation we had.
You're not only looking at Texas and, you know, local Tarrant County and Harris County data and all that. You're looking at U.S. data. There was an increase nationwide from 2006 to '12.
And I don't have data going any further back. Maybe it was a sharper increase when you -- when you look at the bigger time frame. But it seems like 2012 was the peak, and it was declining in years.
Q. Do you have any data on the causes in the increase in opioid prescription rates as presented by Figure 5, 2006 to '12?
A. Yeah, I don't have that today.
But, again, just anecdotal and being involved in a lot of conversations and many different circles -- public health circles, medical circles, there's other nonprofit law enforcement, all of that -- the big buzz around that time has been it's been dispensed pretty frequently, repeated quantities, and all the issues. People are getting hooked onto it.

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That was sort of the summary that I remember from a lot of conversations.
Q. And are you -- are you referring to a physician who practices that are prescribing at a high rate illegally without determination of legitimate medical needs? So just pill mills?
A. I have no way to know that.
MS. AYACHI: Objection, form.
A. So other -- yeah.
Q. (BY MR. CARDI) All right.
So you don't have any specific data or further explanation as to of any cause for an increase in prescription rates?
A. No, but I can give you another anecdotal example. Personal example. And I don't recall exactly the time frame. But had some dental work done. I think I was in Michigan. It was in '11 to '14.
I think on the right side. And they -- the dentist prescribed the opioid, I think, and I don't know -- hydrocodone maybe. I can't remember.
And so I got my ten pills, and I took a couple and didn't really care for them or whatever. And then almost seven or eight days later, I got an automated reminder from the pharmacy, hey, your prescription's ready to pick up.

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Not knowing because I had other meds, I just went through the driveway, picked up my prescription, came home. Here's another ten pills. Like why did I pick this up and pay money for it? I don't need this.

But, you know, that's just how things happen, you know. I mean, I coming back from work. I get an automated call. Okay. Sure. I'll do the drive-through, talking to family on the phone, not even paying attention, and came home with more opioids than I ever needed. So there you go, but that was the time frame.

Q. So you were prescribed an opioid in this case by a dentist, you said?

A. I believe so, yeah.

Q. All right.

And do you believe that that opioid was illegally or improperly prescribed?

MS. AYACHI: Objection, form.

A. No. I had dental work done. I mean, they did the right thing.

I'm just saying that there were other factors involved like automated reminder calls and automatic refilling of a prescription around that time. Hopefully, that practice has subsided.

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And, you know, I was in the drive-through. They just give me meds, and I go home and open the pack; and I'm like, oh, I have eight pills left from ten days ago, and I have ten more pills. What am I going to do with this, you know?

And I'm smart enough. I took it to like a drug reselection program and dumped it in the container, but most people just stick it in their medicine cabinet. And then, you know, that's where I have heard hundreds of stories. I'm sure you have too. Kids got into it. Teenagers got into it. Grandparents got into it by accident. You know, it's just how it is.

Q. (BY MR. CARDI) If it was refilled, isn't it likely at that time that you had a prescription that contemplated a refill?

MS. AYACHI: Objection, form.

A. Yeah. I mean, it authorized a refill.

But, you know, it was automatic called to me. And, you know, it was, hey, your prescription's ready. Come pick it up, and I'm just kind of reselecting from an incident that I remember. It's been a long time, but I'm just kind of giving you some anecdotal examples of what was happening around that time and why this kept coming up on the radar for a lot of people. Just giving you context of that conversation

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we had earlier. How come you knew about this in Michigan and what was your involvement and all that?

And this data somewhat, you know, shows what was happening in the background. More prescriptions being written, dispatched, and so forth.

Q. (BY MR. CARDI) With respect to your anecdotal example, do you believe that the dentist did something improper or illegal?

A. No.

Q. Or is it the pharmacy did something improper or illegal?

A. I don't know that it was illegal, but I think they should have made more of an effort to talk to me as a person versus an automated system. Here's -- your prescription's ready.

Because I got sucked into it. I'll be honest. You know, life's busy. I got a reminder call.

I think I was on the way home, or I got a text message, "your prescription's ready for pick up." And I went and picked it up in drive-through. Was busy, didn't talk to them. Like, yeah, yeah, yeah, here's my card. Give me my drugs, and I'm gone. Because I have other meds, and it was there.

So that's just one example. I'm sure others -- so, you know, I don't know how you

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characterize that, but it could have been done better. Do you really need this? It's a controlled substance. Are you still using it? Maybe some added questions would have been nice, I guess.

Q. And you believe that you did not authorize that refill prior to picking it up?

A. Well, yeah.

I mean, so this is where kind of get legally. Yeah, I authorized the refill. I paid for it and all that.

But, you know, whether that connection between that pharmacy tech dispensing a med and, you know, the automated system, hey, your prescription's ready. Press yes if you're coming to pick it up today. Sure. You know, it was, kind of, all sort of auto authorized, if you will, without real augmented intervention that what am I picking up today and is it really needed? And that's just, you know, one example of many that you'll probably find.

I legally authorized it? Absolutely. I paid for it. I mean, you know...

Q. So the problem in your hypothetical is that there was the use of some sort of automated system and not a phone call to actively discuss whether or not you want refills? Is that what you're saying?

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A. Yeah.
Well -- and, really, some medications you get regular refills on because that's what your prescription is, and that's what your health condition is. And some medicines like this that are highly addictive and controlled substances for a reason, there probably should be more of a discussion between the pharmacist and the patient or the person picking up. Hey, are you still experiencing pain? You still need to use this? Here's some things to watch for. Blah, blah, blah.
Hopefully, that has improved. I haven't had to use them ever since, I don't think. So, hopefully, that changed.
Q. I'm confused in this hypothetical of why you're placing some level of blame on the pharmacy and not the physician for authorizing refills without having that personal conversation as to whether you need it.
Is it not a physician that should be making that determination of need?
A. Absolutely.
I mean, a lot of times, you know, again, this time frame shows the trend where prescriptions were loosely being given with multiple refills. My hope is that they've curved that down because you're starting to

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see on that data that automated refills are not being written. Hopefully, that's the declining trend that you're seeing, and the doctors are being more careful in prescribing.
But at the same time -- and, again, I'm not necessarily placing blame. I'm just giving you context of what was happening at the time when we were seeing this increased trend over this six-year course that you see on the chart. Doctors were loosely prescribing, and pharmacies were automatically refilling. Here's your next prescription. Hopefully, that has stopped.
Because I don't get any more automated calls. I get a text message from time to time. It's time to refill your prescription. Go authorize and I do.
And, now, they put a name of the medication that I'm getting refilled in the text messages. I don't recall if that was done at the time or not, but, you know, here we are.
Q. We discussed earlier that physicians prescribe opioid medications in pharmacies now, correct?
A. Yeah. Absolutely.
Q. And the data in Figure 5 is prescription rates. It's not dispensing rates; is that fair?
A. So rate is number of retail opioid

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prescriptions dispensed per hundred residents. I mean, you don't get it dispensed without both parties, the doctor and the pharmacy working together.
Q. Uh-huh.
A. So it is prescription dispensed per 100 residents.
Q. So why is it that you quickly answered physician did not do anything improper, but you're a little bit unsure about --
(Simultaneous cross-talk ensues.)
A. I didn't say that. I said both parties are --
(Simultaneous cross-talk ensues.)
Q. (BY MR. CARDI) I thought you did.
A. No, I didn't say that.
I told the dentist was probably very loosely writing multiple refills allowed or X times two or X times three or whatever, you know.
So I don't have the prescription handy to go look at it or anything. But I'm just saying if it got done that way, I mean, both parties were probably not being super careful.
Q. (BY MR. CARDI) A dentist that determines the need of the description and the pharmacist that dispenses it?
A. That's right.

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THE CERTIFIED STENOGRAPHER: Counsel, this is the court reporter. I'd like to take a break at the next stopping point.
MR. CARDI: Okay. We can go off the record.
THE CERTIFIED STENOGRAPHER: Thank you.
THE VIDEOGRAPHER: We're off the record at 2:20.
(A break was taken from 2:20 p.m. to 2:40 p.m.)
THE VIDEOGRAPHER: We are back on the record at 2:40 p.m.
Q. (BY MR. CARDI) Doctor, do you agree that over the past ten years since you've been the director of Tarrant County Public County Health, the vast majority of doctors prescribe prescription medications inappropriately?
MS. AYACHI: Objection, form.
A. I don't know that.
Q. (BY MR. CARDI) Do you have any reason to believe that is not true?
A. Just general observations and the trends in data that -- and just that -- you know, again, this is completely -- I won't even bother. Like I have no way to know whether it's accurate or not.

But I did see a lot of pain clinics pop up. Now, are they for good use? Probably. But are they potentially feeding into the problem we have? Probably. But no way to know one way or another.

Q. Do you believe any of the doctors in Tarrant County at any point were part of pain clinics?

A. No, I don't know.

Q. Sure.

A. I mean, doctors are with various specialties. So I'm sure there's some that specialize in pain medicine and others in others. So, I mean, it's just a mix.

Q. So you don't have an opinion as to whether or not the vast majority of doctors prescribe opioid medications inappropriately?

A. No, I don't.

And coming from the medical profession, I would like to presume -- just out of the goodness of my heart, I would like to presume that most people want to do right by their patient. You know, that much I would agree, you know.

Are there practices that are improved over time? Yeah. We should be doing that. That happens. I'm sure that has happened with the medical profession also.

Are there other influences that make your decision-making? You know, a lot of times things are automated. Hey, this is a great thing. Let's do it this way. Sure. Let's try it. Then they realize it wasn't that great. We shouldn't be doing that.

So, you know, I think just being from the healthcare field in general, it's an ebb and flow. It's not a very -- people like to treat medicine as exact science. It's a lot of art a lot of times.

Q. Do you agree the vast majority of pharmacists in Tarrant County dispense medications appropriately and have done so for the past ten years?

MS. AYACHI: Objection, form.

A. I have no way to know that.

Q. (BY MR. CARDI) Do you think it's possible that the vast majority of pharmacies in Tarrant County dispense inappropriately?

A. I have no way to know that.

But same thing, you know, all of these folks, again, I consider, you know, comrades in the healthcare profession, peers and all that. We all go through our trainings and education and all of that. And one of the key tenets is do no harm, and, hopefully, they're all following that.

Q. Ultimately, you just don't know because you

don't have data on all of the physicians or all the pharmacists in the Tarrant County and all of their actions; is that what you're saying?

A. Yeah, I don't -- I don't have the data.

What I do have is the one graph that you saw. That shows that there was a long, sustained increase. And, of course, if we had more data before and after, we could see what the full picture is like. Are we back down to somewhat normal levels? But that 2006 to 2012 time frame seems like a heavy increase of prescription drugs being written and dispensed in Tarrant County.

And I don't have the color graph, but my guess would be Tarrant County because that's what I remember. Tarrant County would be the top in those lines because that's what was striking. But, again, let's look at the color graph, and see if that's what I really recall correctly or not.

(Simultaneous cross-talk ensues.)

A. I'm sorry?

Q. (BY MR. CARDI) Are you referring to Figure 5 of Exhibit 6?

A. Yes, yes.

Q. "Opioid Prescription Rates Per 100 Persons"?

A. Correct, yes.

Q. And you agree that Figure 5 does not show that any pharmacy or pharmacist did anything improper, correct?

A. Not a particular named pharmacy.

I mean, this is very collated prescription data. So a doctor wrote a prescription. A pharmacy filled a prescription.

Q. Right.

A. It doesn't name a pharmacy per se. This is...

Q. Right.

So you agree that Figure 5 does not show that any pharmacy or pharmacist did anything wrong at any time?

MS. AYACHI: Objection, form.

A. Yeah, it's very hard to make any other than that the prescription -- what the graph shows is prescription drug use was increasing very sharply from 2006 to '12. '12 seems to be the peak time, and then we saw a decline.

The other thing I recall is that I believe Tarrant County was the top line above other large counties, state of Texas, U.S. data, but that's my recollection and, you know, I've had some errors. So I'm hoping we can look at the colored graph and see if I recollect correctly or not, but that's what I recall

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from -- the last time I looked at it was 2019. So you've got to give me a little bit of break there not recollecting things correctly, but ---

Q. (BY MR. CARDI) That's fine, Doctor.

(Simultaneous cross-talk ensues.)

Q. (BY MR. CARDI) I'm just trying to confirm that you do not believe Figure 5 shows that any pharmacists or pharmacy did anything improper.

It just shows opioid prescription rates increased from 2006 to roughly 2012; is that fair?

A. It shows opioid prescriptions were being dispensed at a high rate from 2006 to '16 -- or 2006 to '12, an increasing trend.

Q. And it does not show that any pharmacy or pharmacist did anything wrong, correct?

MS. AYACHI: Objection, form.

A. I don't have any way to know that.

How would you know from a graph? That's a very -- that's a leap of faith? Like how would I know that? Would you know that? I don't know that.

Q. (BY MR. CARDI) No, I'm saying what it does not show. Figure 5 doesn't show how many dogs were killed in 2006, right? It also does not show that any pharmacy or pharmacist did anything wrong.

MS. AYACHI: Objection, form.

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A. So -- so here's the thing.

Q. (BY MR. CARDI) Standing alone is all I'm talking about.

(Simultaneous cross-talk ensues.)

A. So it doesn't show any data that -- what it shows is there was a mechanism that prescriptions were being written and filled. And who were the two parties involved? Doctors and the pharmacies. So that much it shows that doctors and pharmacies were prescribing more opioids and filling more opioid prescription from 2006 to '12.

I can't tell you whether they did it right, whether they did it wrong. I mean, that's something y'all can determine by other investigations. This graph doesn't get into any of that detail. It just shows that more prescriptions were being written and being filled, and the two parties involved to make that happen are doctors and the pharmacies. Whether they did it right or wrong is not the intent of the graph.

Q. (BY MR. CARDI) And that was my question. Thank you.

Now, you said that it shows that they were -- you used the words "at a high rate," I believe.

What about Figure 5 shows that it was at any a high rate?

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A. So, again, the peak of the graph is in 2012. And, again, the -- the context is all the other conversations that I mentioned. Every circle that I, you know, visited in health care or in public health circles, substance abuse circles, the conversations around those times were opioid use is on the increase, prescription drug use.

And, you know, again, these are recollections from conversations that there are people finding these prescriptions sitting in drawers and cabinets. And we need to have more tighter controls around how these are being prescribed and have more drug reflection programs so they're not falling into unintended hands, but it's leading to an increase of opioid use and abuse in our community.

So that's kind of the conversation, and this graph does lend context to that conversation.

Q. Based on your anecdotal recollections of this conversation?

A. Yeah.

Q. Standing alone, Figure 5 does not show that -- or establish that 2012 that was improperly or too high of a rate, correct? It just shows it was higher in 2006; is that fair?

A. I have no way to show or tell you whether it

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was proper or improper. But it does show that the use was high. Prescriptions were being written and filled at a high rate.

Q. And Figure 5 does not show that it was -- in 2012, they were being prescribed at a higher rate than desirable or good for society? It just shows higher in 2012 than 2006, fair?

MS. AYACHI: Objection, form.

Q. (BY MR. CARDI) Fair?

A. Need to understand that from the graph.

Q. All right. Thank you.

Do you agree the vast majority of patients who use prescription opioids pursuant to a valid prescription do not --

A. I'm sorry. Say that -- say that again.

Q. Do you agree that the vast majority of patients who used prescription opioids pursuant to a valid prescription do not eventually subsequently use heroin?

MS. AYACHI: Objection, form.

A. And I have no data to show you one way or the other. But like I mentioned before, many of the addictive substances -- this is kind of 101 on addiction, right -- cigarettes, alcohol, medications that are addictive; illicit drug that are addictive -- are all gateway to addiction. That's just how it works.

A lot of times, you have no way to know. You might take a couple -- three pills because you had a dental procedure done, and then your brain activated. I want more. I want more. I want more. There's no way to control that.

You know, I don't know what else to explain that, but it can be a gateway to other drug use, whether it's prescription drug use. Or then if you can't find them, then you go onto the illegal market to find the fix. You know, all of that can happen, and it does happen. But it's just there's no way to explain other than this -- this is how addiction works.

Q. (BY MR. CARDI) Yeah, it can -- no, I -- one can lead to the other you're saying.

And my question was, do you believe the vast majority of patients who use prescription opioids without a prescription eventually use heroin?

MS. AYACHI: Objection, form.

A. I don't have data on that.

Q. (BY MR. CARDI) Do you think it's possible a vast majority of those prescribed who take opioids use heroin?

MS. AYACHI: Objection, form.

A. I don't have data on that.

Q. (BY MR. CARDI) Well, it's one or the other.

So if you don't agree with the first, I imagine you agree with the latter? You think that's not an unfair characterization of the two questions I just presented?

MS. AYACHI: Objection, form.

A. I don't know how else to answer. I don't have any -- any information to accurately answer your question.

Q. (BY MR. CARDI) Okay.

So you believe it is possible then that a vast majority of patients who use prescription opioid assumed without prescription subsequently use heroin is what you're saying? You're saying that's possible?

A. I -- I don't have data to show one way or the other about -- you might want to, like, try an expert in the field that deals with prescription meds and addiction who might have more firsthand data because they deal with it every day. I don't have anything handy to tell you one way or the other.

Is it plausible? Sure. Why not? Absolutely.

I mean, they are gateways to addiction. Sure. Can happen, but I have no way to know that.

Q. Are you familiar with the term "suspicious order" as it relates to the distribution of prescription medications?

A. Suspicious order? No, I'm not. Well, what -- you might have to explain that to me. I'm not familiar with the term.

Q. The term "suspicious order" as it relates to distribution of prescription medications. You're not familiar with it?

A. I am not.

Q. Being that you're familiar with it, is it fair to say that you are not aware of any suspicious orders that were shipped by Kroger or Albertsons' pharmacies into Tarrant County?

A. I am not aware.

Q. Are you familiar with, or have you reviewed any of -- of Kroger's policies or procedures relating to dispensing of prescription opioids?

A. No, I am not.

Q. Are you familiar with, or have you reviewed any of Albertsons' policies or procedures relating to the dispensing of prescription opioids?

A. No, I am not.

Q. Are you familiar with Kroger's training related to dispensing of prescription opioids?

A. No.

Q. Are you familiar with Albertsons' training related to the dispensing of prescription opioids?

A. No.

Q. Do you agree that prescribing a large amount of prescriptions on its own does not necessarily mean there's any illicit activity, or improper, or illegal activity?

MS. AYACHI: Objection, form.

A. Yeah, it's hard to know. You know, there's no way to know that without analyzing what happened afterwards.

Q. (BY MR. CARDI) So the fact that a specific doctor writes a lot of prescriptions, standing alone does not mean there's any diversion going on? There are other factors --

A. I have no way to know that. I have no way to know that.

Q. I didn't mean to interrupt you, Doctor. I apologize.

We spoke of pill mills earlier. What's your understanding of a pill mill?

A. I'm not -- I mean, I've heard the term. I don't know what you mean by it. I mean, I'm not super familiar.

I have my guess. The guess would be a clinic that's writing prescriptions freely, I mean, you know, very loosely. That's -- that's my understanding

from just being around in the community.
But if you have a different definition, feel free to let me know.
Q. Sure. That's roughly my understanding. Physicians that are writing prescriptions without examining and determining a legitimate medical need that the patient has.
Do you have any knowledge of the existence of pill mills under that definition within Tarrant County over the past ten years?
A. I am not aware.
But I'm sure there's other entities like law enforcement or others who might have had complaints, but not -- not to the health department.
Q. You don't have any anecdotal recollections of learning of a -- of a law enforcement bust of a pill mill or anything?
A. Oh, I'm sure a lot of those things hit the news, but I don't have a recollection.
But, like I said earlier -- and it was related to methamphetamines -- but, you know, we did hear for a couple -- three years some buzz about methamphetamine use, and, I guess, networks of distribution in unincorporated areas of the county, but it seems to have subsided.

The conversation has shifted more towards fentanyl. That's anecdotal. I mean, what's 100 percent accurate? I mean, law enforcement may know more than -- than we ever will.
Q. Were you aware in the past ten years of any concerns with residents of Tarrant County doctor shopping? Meaning going around to different medical offices within or without Tarrant County to try to find someone to fill it?
A. Yeah.
So, again, that is, you know, conversations I've heard on -- when they can't get their prescription filled, they'll, you know -- this was kind of a common discussion -- that they are going from doctor to doctor, and we need to make sure prescription data is flowing from EMRs from one clinician office to the other. So they're not filling a prescription for someone who's doctor hopping.
So those are some of the prevention strategies that we would be discussing or had discussion that if we had all the resources, here's how to mitigate some of that. But it's not something that's on my radar recently, but it was when we were more actively pursuing it.
Q. Do you believe that Tarrant County Public

Health has any authority when it comes to sharing of -- of a patient seeking filling of an opioid -- or I'm sorry -- the prescription of an opioid?
MS. AYACHI: Objection, form.
A. No. Yeah, we don't have the authority to share patient information without a due cause. And, generally, due cause is to present an outbreak. So, kind of, a loaded area there.
Can there be methods devised to share information? Eventually, on a limited basis. You know, mostly the identified basis to show trends, yes.
But not to an individual level like, oh, Vinny, is a pill shopper. I don't think that's -- that's going to the case that the health department does that. But we might facilitate, under existing laws, sharing of patient prescription and medical record data between clinical practices.
The technology exists, but a lot of the medical practices and doctors don't implement it correctly and don't always use it. That's where the education and the Health Department acting as the glue comes in. Hey, why don't we put some resources, connect these systems, so they talk to each other? And you get a person who's saying I need medication; you can quickly pull all their history before you write a prescription.

Q. (BY MR. CARDI) Are you referring to PDMP data?
A. I -- I was not. I was talking about actual medical records data from different clinical practices, but it would be nice to have that data also added in. But that's a long, drawn-out processes, and you're going to have to connect with a state data system.
Can it be done? We do that with immunization registry. Lot of immunization data comes back from the state realtime to medical record charts because that's the way connectivity has been established.
Can that be done with the pharmacy data? Absolutely. You just need time and resources.
But what I was mentioning was medical charts and prescription histories being shared between clinicians because it is currently allowable under the law, and the technology exists. It's just not -- people are not implementing it because it's cumbersome; and they're like, yeah, it's fine. We're practicing the way we're practicing.
But the technology is there. You can -- on a click of a button, as long as the patient is authorizing it, request all of their medical records from their previous physicians no matter where they've been and get all that data into their system. Not

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flawless, but it's a start.
Q. You're not suggesting that -- that anything that Tarrant County Public Health could do with sufficient funding would address doctor shopping problems specifically, correct?
A. No.
Q. Okay. I just wanted to make clear.
A. Yeah, no.
I mean, our method is going to be like you're mentioning. Obviously, you've been involved in these conversations. So -- so have we and a lot of other community partners.
So we would all bring them all together. How do we resolve this? And one of the easier ways seems to be enable existing technology to talk to each other. Because it's there. And it's allowed.
The only ingredient that's needed is different hospital and medical offices willing to invest in that technology to talk to each other, training their staff on how to electronically request that data while the patient is there as patient authorization, right?
So if the patient authorizes, all of that data can flow in pretty much instantaneously. And when the patient is being seen by the doctor and go through their medical and history and all that, the doctor can

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see, hey, this person's been prescribed, you know, opioids for a long time. Why are they asking again? And then approach it differently versus, oh, I hurt my back, and I need meds.
Okay. So there's one added tool that can be available. That's what I was, kind of, talking about.
Q. You don't believe that every physician with a DEA license authorized to prescribe opioids has access to data on a particular patients opioid prescription history?
A. I don't know for certain; but, you know, just knowing medical records and data, it is still a very disjointed system.
That's what was being tried, you know, when we were going from paper medical records to electronic medical records. The concept was the patient's medical chart is a complete record, and it goes with the patient no matter what physician they visit, what hospital they visit across the country. That is still not a reality even though the technology exists. It is not an interconnected world on health medical record data.
Q. Do you know whether or not physicians are required to input information on the purchase of controlled substances like opioid medications into a

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database?
A. I believe so.
And that's just because -- and, again, it's a controlled substance. They have to -- and I recall some things from just, like, personal experiences that they don't always like -- are able to, like, e-prescribe. They have to sign something; report something.
I'm not fully familiar with the process, but it's more than like, oh, here's your allergy pill. I mean, you know? It's a little bit more involved in that. And they are more -- there are more requirements around prescribing a controlled substance.
Q. Right.
Are you aware of any instance of a Kroger pharmacy or pharmacist improperly filling a prescription for opioids?
A. No, I am not aware.
Q. Are you aware of any instance of a Kroger pharmacy or pharmacist knowingly allowing the diversion of prescription opioids?
A. No, I'm not aware.
Q. Are you aware of any instance of an Albertsons' pharmacy or pharmacist improperly filling prescription for opioids?

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A. No, I'm not aware.
Q. Are you aware of any instance of an Albertsons' pharmacy or pharmacist knowingly allowing the diversion of prescription opioids?
A. No.
Q. Are you aware of any instance of a Kroger pharmacy or pharmacist knowingly allowing -- I already read that question.
Are you aware of any instance of a Kroger pharmacy or pharmacist -- of any other pharmacy or pharmacist improperly filling a prescription for opioids?
A. Not that I can give you any, like, real accurate data on. I'm not aware.
I'm not in that regulatory authority with the pharmacies, so I have no way to know whether they're doing it right or wrong. I mean, I'm just another person.
Like, hey, you know pharmacy's there. They're doing their job. Hopefully, they're doing it right. I mean, that's just how it is, you know. I'm not in that circle to know whether it's being done right or wrong.
Q. Even anecdotally, I mean, have you heard of a specific instance of any pharmacy or pharmacist within

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Tarrant County improperly filling prescription for opioids?
A. I have not.
But, again, the conversation we had about my experience, was it legally done? Did it authorize it? Were there opportunities for improvement so that things are not loosely prescribed and dispensed? I think that's a good example where there's opportunities for improvement.
But I wouldn't -- that's why I was saying I wasn't blaming the doctor or the pharmacy in that example. I just saying it was just the system was kind of set up fairly messed up.
Q. And you acknowledge that you authorized the sale of that and the receipt and the filling of that prescription?
A. Yes.
(Simultaneous cross-talk ensues.)
Q. (BY MR. CARDI) Go ahead, sir.
A. I said, I fell into that trap. You know, life being busy. You got an automated call. Yeah, I need my prescription. Sure. Fill it up. Because there's more than one prescription, so went in. Picked up. Didn't care what I picked up. And go home. Surprise. Stuff that you don't need.

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Q. And you don't believe that the -- that the dentist or the pharmacy or pharmacist was trying to trap you in that scenario, do you?
MS. AYACHI: Objection, form.
A. I have no way to know that.
Is there -- is there a system that was set up that could have been improved? That's all I can tell you. That knowing now what all has happened, right, and just hearing that there may have been other parties involved that were pushing that this is a comfortable way to do things, maybe there was. I don't know.
But my personal experience and my personal opinion on that is, was there a better way to do it. I mean, my first reaction was, I paid money for something that I don't need, and I can't take it back. Hey, return. Like it's not like just buying groceries from Walmart or whatever. Hey, take it back. I accidentally bought it.
It's a medicine. They dispensed it. They're not going to take it back and refund your money, right?
So all the opportunity I had was lock it in my cabinet or, you know, put it in a drug reselection program, which I'm smart enough to do that. But most people don't know, and they don't really have the

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education to do so. And they just put it in the cabinet. Hey, maybe for later use.
So there was opportunity for improvement. I wasted my time and money to go pick up a prescription that I didn't need. So my frustration at the time was that.
Later, because I'm in public health and realizing what's happening with our community as a whole -- too many prescriptions being written and being filled, and, again, connecting the dots. Maybe it was happening like that -- there was probably some things that could have been done differently and done right versus what was -- what was happening.
Q. (BY MR. CARDI) Do you agree that -- that national/international medical community beliefs and understanding as to the appropriate use of opioids has changed over the past 10, 15 years?
MS. AYACHI: Objection, form.
A. I'm not in the -- practicing, you know, physician anymore. So, I mean, I can only anecdotally tell you that there is a lot more conversations happening. I don't know that they've changed. That's why I keep saying I hope it has changed. You know, I'm starting to see some trends in the data that we saw on the graph. And, hopefully, is leveling off to a more

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reasonable use.
We saw that with antibiotics. So it's not anything that, you know, seems to be different. Antibiotics were pushed very heavily, and then we realized that's not the thing to do.
And, now, you go ask the doctor for an antibiotic, and they try to talk you out of it. And you go home sick and cursing the doctor. I needed that antibiotic, but they usually don't give it to you. It's gone the other way.
Q. (BY MR. CARDI) You don't recall in the past 10 to 15 years the majority of those medical professionals believing in a more liberal use of opioids to treat different levels of pain?
MS. AYACHI: Objection, form.
A. I was -- yeah, I'm not -- I'm not in the practice of medicine, so I'm privy to those circles and those conversations. I've heard what you might have heard on TV and other -- just other -- just being in other circles. Same thing that it was being very liberally used, but I am not directly privy to the practice side of medicine.
THE CERTIFIED STENOGRAPHER: This is the court reporter. Can we go off the record for just one moment, please?

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MR. CARDI: Yes, ma'am.
THE CERTIFIED STENOGRAPHER: Thank you.
THE VIDEOGRAPHER: We are off the record at 3:12 p.m.
(A break was taken from 3:12 p.m. to 3:16 p.m.)
THE VIDEOGRAPHER: We're back on the record at 3:16 p.m.
Q. (BY MR. CARDI) Doctor, are you aware of any wrongful act by Kroger or one of its pharmacies in Tarrant County relating to prescription of opioids?
A. No.
Q. I'm sorry?
A. No, I'm not.
Q. Are you aware of any wrongful act by Albertsons or one of its pharmacists in Tarrant County related to prescription opioids?
A. No, I'm not.
Q. The anecdote we were discussing regarding the dentist prescription, when did that occur?
A. I don't exactly recall the date, but I was in Michigan 2011 to '14. And somewhere in that time frame, I got a dental procedure done on the right side, lower jaw. So somewhere -- venture to say 2012.
And the pharmacy, I do remember actually

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was CVS Pharmacy. So it wasn't Kroger and Albertsons', but it was a pharmacy.
And I, since then, put a note in my phone and carried over -- because it's in my Google profile -- automated pharmacy reminder. So when the call comes, I know what am I looking at. Oh, pay attention. Don't just say yes blindly.
Q. So you get a call, you know who's calling you and what they want?
A. Yeah.
Because -- because a lot of times, it just comes, and the number just shows up and you don't know what it is. You listen. You're busy. You're like yeah, yeah, okay, fine. So I know I have a note in there that it's an automated reminder, and I better pay attention.
Because I didn't -- my big thing was I didn't want to pay for something that I can't return and don't need it. So just being careful about my, you know, dollar use.
Q. Have you -- have you ever been called by a Kroger or Albertsons' pharmacy that has not identified themselves in their purpose in seeking to refill or secure permission to refill a prescription?
A. No.

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MS. AYACHI: Objection, form.
Q. (BY MR. CARDI) Okay. Okay.
MR. CARDI: I have no further questions at this time. I'll turn it over to -- I don't know if Peter has anything or not.
MR. WAHBY: No questions at this time. Thank you.
MS. AYACHI: Can we just take a quick five-minute break?
MR. CARDI: Yeah.
MS. AYACHI: Sure.
THE VIDEOGRAPHER: Okay. We're off the record at 3:19 p.m.
(A break was taken from 3:19 p.m. to 3:29 p.m.)
THE VIDEOGRAPHER: We're back on the record at 3:29 p.m.
FURTHER EXAMINATION
BY MS. AYACHI:
Q. Dr. Taneja, I have just a few questions for you.
A. Sure.
MS. AYACHI: Greg, I added an exhibit into the shared folder. Would you be able to put that on the screen for me?

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MR. HOLDERMAN: I'm sorry. Did you put it in the exhibit share -- in your exhibit share private folder?
MS. AYACHI: Yes.
MR. HOLDERMAN: I don't have access to that. I didn't realize. Give me one second here.
MS. AYACHI: Sure.
MR. CARDI: This probably is not the easiest way, but, Leila, you could send it to me, and I could put it in mine; and he could do it. I can't imagine that's the easiest way, though. I'm just offering.
MR. HOLDERMAN: That honestly may be the fastest way. I'd have to --
MR. CARDI: Okay.
MR. HOLDERMAN: -- make a request to the exhibit share --
MS. AYACHI: Yeah, whatever's easiest.
Okay. Michael, go ahead and give me your email address, please.
MR. CARDI: M, Cardi, C-A-R-D-I @bowlesrice.com. B-O-W-L-E-S.
MS. AYACHI: All right. Sent.
MR. CARDI: It should be in there, Gregg.
MR. HOLDERMAN: Okay. I see it listed as

"Exhibit 7"; is that correct?
MS. AYACHI: That's how I named it. You can change the name. I'm not sure. However you need to.
MR. HOLDERMAN: Oh, okay. Just to clarify for the record, Exhibit 8 has been introduced.
(Exhibit 8 marked.)
Q. (BY MS. AYACHI) Doctor, will you open your binder to Exhibit 7, Tab 16.
A. Exhibit 7?
Q. Yes. Tab 16 in your binder.
A. Oh, okay. Tab 16, yes.
Q. And then --
MS. AYACHI: Sorry, Gregg. I do -- I do actually want for you to pull up the Exhibit 8 so that we can just make sure that these are the same documents.
MR. HOLDERMAN: (Complies.)
MS. AYACHI: Thank you.
And, please, scroll down about four pages, I think.
Q. (BY MS. AYACHI) So, Doctor, I will represent to you that this is the same document that you see at Tab 16, but a color version of it.
A. Yeah.
Q. And attached to this is a parent -- the parent

email that accompanies this.
Were you provided the parent email when you were asked about this exhibit earlier?
A. I -- I don't have that in my binder, the parent email. I do have the same document in a black and white -- black-and-white version. This one's the colored version of that.
Q. And let us know if you want Greg to scroll at all, but initially I'll just direct you to the parent email.
MS. AYACHI: So if we can go back to the beginning. Okay. So -- sorry. Scroll down to the second page. My apologies.
MR. HOLDERMAN: (Complies.)
Q. (BY MS. AYACHI) So this -- this document, Tarrant_00343779, is the parent email to the original Exhibit 7.
Doctor, would it have been helpful for you to have this parent email while giving your testimony earlier?
MR. CARDI: Objection, form.
A. Yes.
MS. AYACHI: Please, go ahead.
MR. CARDI: Go ahead.
Q. (BY MS. AYACHI) And I invite you just to read,

you know, see the exchanges going on.
Can you explain to us why this would have been helpful for you to have?
A. Right.
So I would draw your attention to the second paragraph. It talks about (as read): "Please note the results of the Texas State Board of Pharmacy are still pending. These data will allow us to describe the persons receiving the prescriptions by gender, city, zip code, number of pills prescribed, number of refills available. We're waiting on some verbal clarification from the State Board of Pharmacy; and, therefore, do not have an estimate of those results or when they may be available. With over 3 million prescriptions filled by a licensed pharmacists located in Tarrant County per year, it is understandable, you're going to take time to clean that data and have all of that analyzed to have some meaningful results."
But it would lend more context to the trends that we were seeing from these national and state data sets to have, you know, that data. And this would help me recollect what I was saying, and maybe give you more accurate interpretation of what we're looking at in the graph.
Just for context, this is the first time

I'm looking at it since 2018, right? So a lot goes on. Oh, yeah, I remember that graph. But as you all saw, I kind of remembered the time frame wrong and, you know, wasn't very accurate, but it's seven years ago. So these type of things do help jog that memory because, you know, it makes it more accurate.
Q. Does this parent email help inform or -- or does it cause you to want to clarify or add to any of your prior testimony with regard to any of the figures that you saw in the original Exhibit 7?
So feel free to --
A. Yeah.
Q. -- to look through the binder and refer to any of the figures that were discussed earlier and provide any clarifications that you see that you might want to add.
A. Yeah.
So one thing is that I would probably, you know, want to go, you know, later maybe look and see if there was more details available or whatever. But for today, I want to go back to look at Figure 5. Because what I recollect was that Tarrant County was on top. And, hopefully, I'm still recollecting it correctly. Yes, it does appear to be the case. The red line.
So, again, context on why opioid

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prescriptions were a hot topic in Tarrant County. And even though I will concede that I remembered the time frame wrong and 2012 to '16 shows a downward decline nationally, Tarrant County, state of Texas, and many locations, the point that I was trying to make was 2006 to '12, we were in an uptrend. And if you would note, Tarrant County was on top of everybody else -- Harris County, Dallas County, Travis County, State of Texas. U.S. data that has the hotspot West Virginia part of the data, we beat out everybody in prescribing more opioids and dispensing more opioids. That's all this shows. But we can extrapolate that. That led, you know, to a situation in Tarrant County that caused more opioid-related addiction and more issues.

Because we saw some of the aftermath of all of that. And as a result, there we are discussing that. So that's -- that's one thing that was missing because it was not a colored chart that we were looking at. But I remember that Tarrant County was in trouble looking at this data. So there we are on that one.

If we can go to the next page. I know we didn't cover some of those, but I think there's some useful information there. And some of that is data from other sources.

So -- and, again, it's hard to sort of just

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look at the report and say what may be causing that. But look at the first draft, No. 6. From 2000 all the way to 2014/'15 time frame, it was a steady increase in opioid exposure calls to Texas Poison Control Center for Tarrant County residents. So not every data set is going to exactly match up, but they fill in the gaps of what was happening in our community.

So prescription charts are showing 2006. '12 was the peak, and then there was a decline; but we don't have before and after. This one goes a little bit beyond that, and Poison Control calls usually are overdose related. You're seeing a steady increase from all the way 2000, all the way into 2015/'16 time frame. So beyond what we saw.

Corroborating that is Figure 7 --

Q. I'm sorry, Doctor. Let me just --

A. -- which is broken down --

Q. I just want to clarify. Figure 6, is that the one entitled "Number of Opioid Exposures Reported to the Texas Poison Center Network Among Tarrant County Residents 2000 to 2017"?

A. That is correct.

Q. Okay. Please continue.

A. And then on No. 7, again, it is broken down by type of opioid substance being used, legal or illegal;

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and you can see some trend there. But the big-picture trend that I wanted to point out: More data gives you a better picture. Even though on the prescription front, we may have seen, hey, there was a decline. This is not really true on why the poison -- you know, the Poison Center data was showing what was happening in the community.

So we're seeing an increasing trend all the way into 2015, 2016, and then a little bit of a decline in '17. But the point here is, all those prescriptions got written. And, again, anecdotally what we heard was people locked them away in their kitchen cabinet, bathroom cabinet later to be found by teenagers, adults, children.

It lends itself to somewhat of a bad conversation. Yeah, Poison Center Control calls continued on. Despite the decline in prescription being written and dispensed, we were still on an uptrend because there was so much leftover medicine sitting in our community.

And, again, this is -- you know, I can't just draw that conclusion from the graph, but it does lend itself to the story that we keep hearing in public health and medical circles; and that's what happened. It does paint that picture when you look at it with that

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context in mind. So there is some value to looking at more of this data there.

And then I think a final, maybe couple of, charts I want to show. On the next page, there's one line. The second bullet point that I would like to read before the chart. Go back up.

MR. HOLDERMAN: (Complies.)

A. (As read): "The drug tramadol had the greatest increase in reports among Tarrant County residents with almost 800-percent increase from 11 reported exposures in 2000 to 97 reported exposures in 2017." And just being in the public health prevention world, reports are the tip of the iceberg. So if we saw an 800 increase in -- 800 percent increase in reports, you can just imagine how much got unreported.

And the graph there talks about Tarrant County residents that had intentional exposures. Meaning, they sought out by purposeful action these opioids, and then later had overdoses and adverse reactions and things like that.

So there's more context to this. The story didn't end that, oh, in 2012 prescriptions peaked, and then they declined. The damage continued on in our community for years until 2017 almost.

And I'm hoping that it continued the

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downward trend. I just don't know what the rest of the picture is. So that's No. 8.

And then just lending itself to some discussion about where Public Health Department could have been useful in strategies, No. 9. So this is where it's useful to collect data and look at that, right? So a lot of the opioid-exposure situations got reported to Poison Control Center. And they found that a majority of those situations, naloxone was not recommended, was not used, things like that. And that's a learning opportunity for all of us from a prevention standpoint, from a public health standpoint.

So this is just an example to show what public health would be able to bring to the table when given all the resources, the dollars, and the investments in preventing this situation from becoming a bigger crisis than it already has been.

So that's kind of what I wanted to show.

Other charts are -- No. 12 might be of interest to, y'all. Related to e-data. Because we talked about it. And it's, I think, the latest time frame that we had in this report.

So if we want to go to Page 8, Figure 12. So it is a time frame, I think, from 2017 to early 2018. Continuing to show a disease surveillance trend in the

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ERs opioid-related visits on the increase. And this is, like, early part where we weren't even like fine tuning our algorithm or investing a lot of effort in trying to study all of that.

So this was just kind of an indicator, oh, there's a problem. We should invest more into this. This is -- you know, just the starting of everybody, kind of, really starting to kind of pay attention that we have problems in our community that needs to be addressed.

So color charts and those emails do lend a lot of context to the story that we've all heard in public health and other circles; that there is a real problem in our community, and something needs to be done about it.

It's up to y'all and others to determine, you know, parties responsible and how the mechanisms work and all of that. My job here is tell you that the problem was real, and there were two factors, liberal prescription/liberal dispensing.

And, later, what you saw was the aftermath that we can show in the data.

Q. That's all the questions I have for you, Doctor.

MS. AYACHI: Pass the witness.

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FURTHER EXAMINATION

BY MR. CARDI:

Q. Doctor, if I recall your testimony correctly, prior to the introduction of Exhibit 7 in color, you had testified it was your recollection that Figure 5 showed Bexar on top, right?

A. I thought Travis was on top, but that's -- that's what I thought at the time.

But I was kind of taken aback when I looked at the chart that I recollected wrong. I thought we were ending in an incline, but we were ending in a decline. So I was kind of not sure of my own recollection. One that I was like maybe Travis was on top. I don't know.

But in the back of my head, I thought Tarrant was on top, and that was right. And I did try to correct that a couple of times later that maybe, I think, on the black-and-white chart, it's Tarrant County on top.

Q. Is Exhibit 7 and Exhibit 8 is a color copy of Exhibit 7? Is it the final draft of the report?

A. I'm not sure if it's the final draft, but it's -- it's the same exact copy that I'm looking at on the black-and-white version. Same Bates number, same draft, same everything.

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Q. Well, beginning Exhibit 8, speaks (as read): "Awaiting for variable clarifications," indicating that it's not a final draft potentially; is that fair?

A. Yeah.

And, again, that's why I said when we started talking now is that I would have probably liked to go back and see if there is a revised version, or did we not find other data to revise any further? But this seemed to be a draft that they found in my email, I guess.

Q. And as you sit here today, you don't know what the final draft presented, whether or not the numbered change?

A. Yeah, I don't -- I don't recall any other because it's been a long time. I don't know that the numbers would have changed very much.

What may have been added was the state pharmacy board data because I do recall a whole another draft, but it could have been getting confused.

Q. So I believe your testimony walking through these figures is that there was an increase in prescriptions shown by Figure 5. That, coupled with your anecdotal recollection of pills being left in cabinets and then stolen by others, coupled with the later increase in calls to the poison center and such,

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creates a connection between what you called liberal prescription and liberal dispensing and present problems with opioids; is that fair?

MS. AYACHI: Objection, form.

A. Not present. But to the point it was showing the chart all the way up to 2016, '17.

Because, like I said, last three years have been a blur. And my ear has been more to COVID than to opioids. Still, what's filtering in is, hey, fentanyl has burst onto the scene as a major problem. It was not. If you look at one of the charts, No. 8, I believe -- or No. 7. Fentanyl was there but, it wasn't a big deal. But, now, what I expect if we pull up recent data, we would probably see a lot more than that. But, again, I don't have any data beyond 2017 in front of me to tell you what the current situation is.

What I was trying to say is that even though on this chart No. 5, Figure No. 5, it does appear that we peaked in prescriptions in dispensing in 2012, issue in our community continued on three or four years later and a continued increase in overdoses and calls to the poison center probably corroborate that with Medstar and getting ambulance calls and law enforcement getting calls and all that. But one would venture to say, it was because the story was being true was true. That a

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lot of extra medicine got left over in cabinets and fell into unintended hands. But then there's data to show that they were intentionally being sought out.

So it became a cycle where people either themselves got hooked or others got hooked and then sought out intentional exposure to opioids.

Q. (BY MS. AYACHI) Throughout today, you've refused to speculate based on data not being present in front of you and based on potentially a lack of perceived qualifications. I'm trying to confirm. Are you now saying that these figures lead you to the conclusion that an increase in prescriptions during this time frame led to resulting increase overdose on prescription and illicit opioids? Have you come to that conclusion based off this data?

MS. AYACHI: Objection, form.

A. No, no. Not at all.

You know, all I'm trying to say is when I hear those stories that too many prescriptions were in our community available to people and a lot of that fell into other hands where it was not intended to go to, and then I look at this data, it does makes sense. The story does sound recently found true. But it doesn't conclusively prove any of that.

So, I mean, I'm very clear. I'm just

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saying that prescriptions went on a rise and then went on a decline. It just shows just that.

Later, we see poison control calls went up related to prescription meds even though there were less prescriptions being prescribed. So what that tells me is that potentially -- that story was true that there was a lot left over in our community because we were beating out everybody else on prescriptions.

So are there other explanations possible? Sure. But I've heard it too many times, and then I look at the data, and I was, like that sounds like a logical explanation.

Q. (BY MR. CARDI) But you don't feel comfortable on any level speculating as to whether or not the vast majority of patients who used prescription opioids pursuant to a valid prescription and used as directed by a doctor subsequently used heroin?

MS. AYACHI: Objection, form.

A. I have no way to know any of that.

Q. (BY MR. CARDI) Okay.

In light of the colored figure present in Exhibit 8, are you aware of any instance of Kroger pharmacy or pharmacists improperly filling a prescription for opioids?

A. No.

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Q. In light of witnessing Exhibit 8 in color, are you aware of any instance of a Kroger pharmacy or pharmacist knowingly allowing the diversion of prescription opioids?

A. No.

Q. In light of the colored copy present in Exhibit 8, are you aware of any instance of an Albertsons' pharmacy or pharmacist improperly filling a prescription for opioids?

A. No.

Q. In light of the color copy present in Exhibit 8, are you aware of any instance of an Albertsons' pharmacy or pharmacists knowingly allowing the diversion of prescription opioids?

A. No.

Q. All right.

MR. CARDI: I have no further questions.

FURTHER EXAMINATION

BY MR. WAHBY:

Q. Yes, sir, this is Peter Wahby. I'm representing Albertsons in connection with the case you've appeared on -- appeared for today. Just a couple of questions.

You referred to liberal dispensing.

Do you recall that?

A. Yes.
Q. Do you have any evidence that Albertsons or an Albertsons' affiliated pharmacy or pharmacists engaged in any liberal dispensing practices?
A. No, I'm not aware.
Q. Do you have any evidence that any Kroger or Kroger-affiliated pharmacy or pharmacist engaged in any liberal dispensing practices?
A. I am not aware.
Q. Okay.
MR. WAHBY: No further questions. Thank you, doctor.
MS. AYACHI: And I don't have any other questions.
Thank you so much, Dr. Taneja. I really appreciate your time, and we hope you can get to the county judge before the end of the day.
THE WITNESS: We'll find out. Thank you so much.
THE VIDEOGRAPHER: We're off the record at 3:55 p.m.
THE REPORTER: Just for the attorneys, real quick housekeeping. Since this is Federal, do you have any other stipulations you want to add to the record?
MR. CARDI: I don't believe so. None from

my end.
MS. AYACHI: None from my end either.
(Proceedings concluded at 3:55 p.m.)

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

IN RE: NATIONAL PRESCRIPTION OPIATE LITIGATION) MDL No. 2804
) Case No. 17-md-2804
) Judge Dan Aaron Polster

REPORTER'S CERTIFICATION
DEPOSITION OF VEERINDER TANEJA, MBBS, MPH
August 30, 2023

That the deposition transcript was delivered to Mr. Michael Cardi.
That a copy of this certificate was served on all parties and/or the witness shown herein on _____.
I further certify that pursuant to FRCP Rule 30(f)(1) that the signature of the deponent:
____ was requested by the deponent or a party before the completion of the deposition and that signature is to be before any notary public and returned within 30 days from date of receipt of the transcript.
If returned, the attached Changes and Signature Page contains any changes and the reasons therefore:
____ was not requested by the deponent or a party before the completion of the deposition.

I certify that I am neither counsel for, related to, nor employed by any of the parties or attorneys in the action in which this proceeding was taken, and further that I am not financially or otherwise interested in the outcome of the action.
Certified to by me this 18th day of September, 2023.

ABIGAIL GUERRA, Texas CSR 9059
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September 18, 2023

To: Sadie Turner, Esq.

Case Name: National Prescription Opiate Litigation - Track 9 (Tarrant County)
Veritext Reference Number: 6055208
Witness: Veerinder Taneja, MBBS, MPH Deposition Date: 8/30/2023

Dear Sir/Madam:

Enclosed please find a deposition transcript. Please have the witness review the transcript and note any changes or corrections on the included errata sheet, indicating the page, line number, change, and the reason for the change. Have the witness' signature notarized and forward the completed page(s) back to us at the Production address shown

above, or email to production-midwest@veritext.com.

If the errata is not returned within thirty days of your receipt of this letter, the reading and signing will be deemed waived.

Sincerely,

Production Department

NO NOTARY REQUIRED IN CA

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 6055208
CASE NAME: National Prescription Opiate Litigation - Track 9 (Tarrant County)
DATE OF DEPOSITION: 8/30/2023
WITNESS' NAME: Veerinder Taneja, MBBS, MPH
In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.
I have made no changes to the testimony as transcribed by the court reporter.

_____ _____
Date Veerinder Taneja, MBBS, MPH
Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal

this _____ day of_____, 20____.

_____
Notary Public
_____
Commission Expiration Date

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 6055208
CASE NAME: National Prescription Opiate Litigation - Track 9 (Tarrant County)
DATE OF DEPOSITION: 8/30/2023
WITNESS' NAME: Veerinder Taneja, MBBS, MPH
In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.
I have listed my changes on the attached Errata Sheet, listing page and line numbers as well as the reason(s) for the change(s).
I request that these changes be entered as part of the record of my testimony.

I have executed the Errata Sheet, as well as this Certificate, and request and authorize that both be appended to the transcript of my testimony and be incorporated therein.

_____ _____
Date Veerinder Taneja, MBBS, MPH

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:
They have read the transcript;
They have listed all of their corrections in the appended Errata Sheet;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.
I have affixed my name and official seal this _____ day of_____, 20____.

_____
Notary Public

_____
Commission Expiration Date

ERRATA SHEET
VERITEXT LEGAL SOLUTIONS MIDWEST
ASSIGNMENT NO: 6055208
PAGE/LINE(S) / CHANGE /REASON

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_____ _____
Date Veerinder Taneja, MBBS, MPH
SUBSCRIBED AND SWORN TO BEFORE ME THIS _____ DAY OF _____, 20_____ .

_____
Notary Public

_____
Commission Expiration Date